University of Alberta

A Case Study of a Prenatal Nutrition Program Based on Education, Community Participation, and Capacity Building

by

Ellen May Vogel ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy

in

Community Nutrition

Department of Agricultural, Food and Nutritional Sciences

Edmonton, Alberta

Fall, 2001

National Library of Canada

Acquisitions and Bibliographic Services

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque nationale du Canada

Acquisitions et services bibliographiques

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

Our file Notre référence

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-69010-5

Canada

University of Alberta

Library Release Form

Name of Author:	Ellen May Vogel
Title of Thesis:	**A Case Study of a Prenatal Nutrition Program Based on Education, Community Participation, and Capacity Building**
Degree:	Doctor of Philosophy
Year This Degree Granted:	2001

Permission is hereby granted to the University of Alberta Library to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly, or scientific research purposes only.

The author reserves all other publication and other rights in association with the copyright in the thesis, and except as hereinbefore provided, neither the thesis nor any substantial portion thereof may be printed or otherwise reproduced in any material form whatever without the author's prior written permission.

Ellen Vogel

10212 – 136 Street NW
Edmonton, AB
T5N 2E4

Date: July 25, 2001.

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "A Case Study of a Prenatal Nutrition Program Based on Education, Community Participation, and Capacity Building" submitted by Ellen May Vogel in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Community Nutrition.

....

Dr. T. Clandinin, Chair

....

Dr. K. Raine, Supervisor

....

Dr. N. Gibson

....

Dr. L. McCargar

....

Dr. V. Tarasuk, External Examiner

Date: July 25, 2001.

Abstract

This qualitative case study examined Healthy Start for Mom & Me (HSMM)--a collaborative, multi-faceted prenatal nutrition program targeting high-risk women and teens in Winnipeg, MB. The purpose of the study was to desribe the dynamics of HSMM operations; to understand the experiences of participant women, staff, and community partners; and to interpret how the program "worked" within a socio-environmental context.

The research focused on two of HSMM's eight community-based sites. Individual interviews (n=21) were conducted with program staff and community partners affiliated with the two sites, as well as with key informants. Two focus group interviews--one at each site--were held with participant women (n=23). Semi-structured and open-ended questions were used to provide maximum opportunities for exploration of topics of mutual interest. Direct observation and document reviews generated additional data on the functioning of HSMM.

An empowerment framework, based on a holographic design, was developed to organize and analyze the data. Findings indicated that HSMM's "Kitchen Table" approach increased intersectoral action and local empowerment on four levels. First, interventions targeted the individual participant and, on occasion, her family (i.e., personal care). Second, HSMM's drop-in sessions increased empowerment at the level of the small group primarily through the actions of the peer outreach workers (i.e., small group development). Third, the community organization process enabled HSMM to offer a broad range of services to marginalized women that were beyond the scope and/or

mandate of any one individual agency or department (i.e., community organization). Fourth, as the program consolidated, HSMM's "reach" in the Winnipeg community increased to include strategies pertaining to coalition building and advocacy. Further, the practices of HSMM's interdisciplinary teams enhanced intersectoral action by developing the vertical and horizontal linkages necessary to promote population health.

Recommendations for practice and research pertained to planning and implementing community-based programs targeting marginalized populations; expanding dietetic education and training to reflect a population health approach; and broadening the rationale for prenatal health beyond the prevention of low birthweight in order to increase community awareness of the determinants of prenatal/birth outcomes and the resultant social and economic implications.

Acknowledgements

I wish to express my sincere gratitude to the many individuals and organizations from whom I have received advice and assistance. In particular, the members of my supervisory committee--Dr. Kim Raine, Dr. Tom Clandinin, and Dr. Nancy Gibson--are deserving of special thanks and recognition. I am also indebted to Dr. Linda McGargar and Dr. Valerie Tarasuk for their participation as members of the thesis examining committee.

My visionary advisor, Dr. Kim Raine, suggested that I investigate "Healthy Start for Mom & Me" for my doctoral research. I am very grateful for her encouraging suggestion and for her ongoing guidance and support. I was pleased and honoured to be Dr. Raine's first Ph.D. student. Together, Dr. Raine and I took great pride in my being the first doctoral candidate in the Department of Agricultural, Food and Nutritional Sciences to complete a thesis in the area of Community Nutrition.

Without the support of many individuals involved with "Healthy Start for Mom & Me," this study would not have come to fruition. Project staff, community partners, mothers, and mother-to-be served as inspiring teachers and mentors in the art and the science of community development. I am deeply indebted to staff and community partners for their willingness to share their experiences and for giving me permission to observe their tireless efforts in the Winnipeg inner-city community. Their honesty and generosity of spirit in sharing their successes and failures made this study possible.

I owe a particular debt to Gail Wylie, the founding manager of "Healthy Start for Mom & Me." Beyond her talent as a community organizer and builder, her political conscience, her incandescent spirit, and her art of friendship, she is a remarkable individual from whom I have learned, and shared, so much. The founding dietitian of "Healthy Start for Mom & Me," Lauranne Matheson, now residing in Ottawa, also deserves my great gratitude for sharing with me her wisdom and insights, her deep sense of social justice, her joys and her sorrows, and, above all, her passion for community.

Others to whom I am indebted include past and present members of the "Healthy Start for Mom & Me" Steering Committee for their tremendous encouragement and support. In particular, I would like to thank my mentor Ruth Diamant, Chair of the

Steering Committee, for her belief in, and encouragement of this research and for her countless contributions since its inception. Special thanks as well to Corinne Eisenbraun who represented Dietitians of Canada, the sponsor of "Healthy Start for Mom & Me."

The successful completion of my doctoral research would not have been possible without the immeasurable support of my colleagues at Health Canada. Management; and staff in the Population and Public Health Branch, regionally and nationally, encouraged my efforts and found ways to bend the bureaucracy to accommodate my work. To all those involved, especially Don Onischak, Brenda Cantin, Sharon Gribbon, and Judy Watson, a very special vote of thanks.

The magnitude of a research project like this one can be overwhelming. Without the patience, love, and support of family and friends, success would remain elusive. I am grateful to my husband, Bill Muirhead, for always being there for me, convincing with his words, and reassuring with his actions. My Mother, Nora, and my late Father, Garson, also deserve a special debt of thanks for teaching me, at an early age, that to those whom much is given, much is expected in return. I am privileged to have a wonderful mother-in-law, Alice Muirhead, who watches from afar, and quietly reminds Bill and me of the most important things in life. My heartfelt thanks also go to Dr. Edward Holdaway, Professor Emeritus, University of Alberta, and his wife Doris, for taking Bill and me "under their wings" as together we pursued a shared dream of completing our doctorates. We will always be grateful to Ted and Dee for their encouragement and unconditional support.

In closing, as a very significant chapter in my life comes to an end, I am reminded that I have been truly blessed in my journey thus far:

> *If enjoyment of life is a valid parameter of success, then I have indeed been successful. A happy childhood, an education and profession which fascinated me, and with love and companionship doubly blessed. (Anon)*

Table of Contents

Page

CHAPTER 1: OVERVIEW OF THE STUDY 1
  1.1. Introduction 1
  1.2. Rationale for the Study 2
  1.3. At-Risk Groups and Lifestyle Issues Related to Poor Birth Outcomes 4
  1.4. Background to Study 5
    1.4.1. The Canada Prenatal Nutrition Program--An Overview 5
    1.4.2. CPNP Intended Outcomes 6
    1.4.3. CPNP Guiding Principles 6
    1.4.4. CPNP Project Components 7
    1.4.5. CPNP National Evaluation Framework 7
  1.5. Brief Description of the Case--A CPNP Initiative in Winnipeg 9
    1.5.1. Data on HSMM Participants 10
  1.6. Purpose of the Study 11
  1.7. Major Research Questions 11
  1.8. Specific Research Questions 11
  1.9. Significance of the Study 12
CHAPTER 2: LITERATURE REVIEW 14
  2.1. Introduction 14
  2.2. Overview of At-risk Groups and Lifestyle Issues Related to Poor Birth Outcomes 14
    2.2.1. Adolescent Pregnancy 15
    2.2.2. Smoking 16
    2.2.3. Alcohol Abuse 17
    2.2.4. Illicit Drug Use 18
    2.2.5. Socioeconomic Status 18
    2.2.6. Health Status Disparities (Aboriginals and Recent Immigrants) 20
    2.2.7. Family Violence 21
    2.2.8. Gestational Weight Gain and Maternal Nutrition 22
      2.2.8.1. Gestational Weight Gain 22
      2.2.8.2. Maternal Diet and Nutrient Intake 23
    2.2.9. Indicators for Referral to a Nutrition Professional 27
    2.2.10. Medical Conditions 27
      2.2.10.1. Gestational Diabetes Mellitus 27

        2.2.10.2. Pre-eclampsia 28
        2.2.10.3. HIV in Pregnancy 28
  2.3. Prenatal Health Promotion Literature 29
  2.4. Key Canadian Prenatal Nutrition Programs 32
  2.5. Related Health Promotion/Education Literature 34
    2.5.1 Society as the Locus of Change 35
    2.5.2. Community-level Change Theories 36
    2.5.3 Individual-level Change Theories 39
  2.6. An Integrated Model of Community Health Promotion 43
  2.7. An Empowerment Framework 45
    2.7.1 Sphere of Personal Care 46
    2.7.2 Sphere of Small Group Development 47
    2.7.3. Sphere of Community Organization 49
    2.7.4. Coalition Building and Advocacy 50
    2.7.5. Political Action 52
  2.8. The Role of Empowerment as a Health-enhancing Strategy 52
  2.9. An Empowerment Education Approach 55
  2.10. The Concept of "Cultural Brokerage" 58
  2.11. Interdisciplinary Collaboration 59
  2.12. Social Support 61
  2.13. Community Development 64
  2.14. Food Security 67
  2.15. A Socio-environmental Approach to Prenatal Health Promotion 69
  2.16. Recommendations for Action Based on the Literature 70
CHAPTER 3: RESEARCH DESIGN AND METHODS 72
  3.1. Introduction 72
  3.2. Critical Social Theory 72
  3.3. Justification and Strengths of a Case Study Approach 74
  3.4. Role of the Qualitative Case Researcher 77
    3.4.1. Bounding the Unique Case 77
        3.4.1.1. Site #1 – Evergreen Community Centre 78
        3.4.1.2. Site #2 – Willow Community Centre 79
    3.4.2. Focus on Prenatal Care Versus Infant Care 80
    3.4.3. Distinction Between Case Study and National CPNP Evaluation 80

3.5. Data Collection Methods 81
3.5.1. Participant Observation--HSMM Women 81
3.5.3. Focus Group Interviews 83
3.5.4. Individual Interviews 84
3.5.5. Elite Interviews 85
3.5.6. Document Review 86
3.5.7. Physical Artifacts 86
3.6. Principles of Data Collection 86
3.6.1. Principle 1--Using Multiple Sources of Evidence 86
3.6.2. Principle 2--Creating a Case Study Database 87
3.6.3. Principle 3--Maintaining a Chain of Evidence 87
3.7. Selection of Research Participants 87
3.8. The Use of Purposeful Sampling 88
3.8.1. Snowball Sampling to Identify Key Informants 90
3.9. Data Analysis 90
3.10. Trustworthiness of the Study 93
3.10.1. Establishing Credibility 93
3.10.1.1. Peer Debriefing 93
3.10.1.2. Member Checks 94
3.10.1.3. Negative Case Analysis 94
3.10.1.4. Progressive Subjectivism 94
3.10.2. Establishing Transferability 95
3.10.3. Dependability 95
3.10.4. Confirmability 96
3.11. Assumptions 96
3.12. Delimitations 98
3.13. Limitations 98
3.14. Ethical Considerations 99
3.15. Reflections on Methodology 99
CHAPTER 4: HSMM'S "KITCHEN TABLE" APPROACH 102
4.1. Introduction 102
4.2. Section 1--The Context of the "Kitchen Table" Approach 104
4.3. Isolation as a Social Determinant of Health 106
4.4. An Overview of HSMM's "Kitchen Table" Approach 110

4.5. The Setting of the Drop-In Sessions 116
4.6. Preparing Food and Eating Together 129
4.7. Offering Food--Milk and Juice Coupons 133
4.8. HSMM's Meal/Recipe Bag 135
4.9. Future Plans 137
    4.9.1. Birth Planning 137
    4.9.2. Community Kitchen 139
    4.9.3. HSMM Health Fair 140
4.10. Section 2--Theoretical Constructs 141
    4.10.1. The Empowerment Holosphere in HSMM 141
4.11. Summary 143
CHAPTER 5: THE EXPERIENCES OF PARTICIPANT WOMEN IN HSMM 146
5.1. Introduction 146
5.2. Section 1--Experiences of Participant Women in HSMM 147
    5.2.1. Sphere of Personal Care 147
    5.2.2. Reflections on Focus Group Interviews 148
    5.2.3. Willow Community Centre Focus Group--11 Participants 149
    5.2.4. Evergreen Community Centre Focus Group--12 Participants 152
5.3. Participant Women's Experiences of the Drop-in Sessions 154
5.4. Learning New Things 158
5.5. Gaining Self-Confidence 161
5.6. Making Friends 165
5.7. Significance of Food and/or Coupons 168
5.8. Sharing Information With Significant Others 172
5.9. Suggestions for Improvement 173
5.10. Section 2--Theoretical Constructs 174
5.11. Summary 175
CHAPTER 6: HSMM PEER OUTREACH WORKERS: BRIDGING THE GAP 178
6.1. Introduction 178
6.2. Section 2--HSMM's Peer Outreach Workers: Bridging the Gap 180
    6.2.1. Sphere of Small Group Development 180
    6.2.2. The Culture of Inequality 180
    6.2.3. Dealing With Diversity 182
6.3. Role of the Peer Outreach Worker 183

6.4. Introducing HSMM's Peer Outreach Workers 185
6.5. Grounding the Team 192
6.6. Connecting With Women 196
6.7. Lessons Learned 203
6.8. Section 2--Theoretical Constructs 211
    6.8.1 Small Group Development in HSMM 211
6.9. Summary 212
CHAPTER 7: COMMUNITY ORGANIZATION IN HSMM 216
7.1. Introduction 216
7.2. Section 1--Definition of Community Organization 216
7.3. Community Organization in HSMM 218
    7.3.1. Sphere of Community Organization 218
    7.3.2. Community Organization in HSMM--An Overview 219
7.4. Phase 1--"Preparing the Earth" 219
    7.4.1. Securing a Sponsor 220
    7.4.2. Recruiting a "Gardener" 220
    7.4.3. The Significance of Timing 223
    7.4.4. Health Canada's Contribution 225
7.5. Phase 2--"Planning the Garden" 226
    7.5.1. Starting With the Voices of Participant Women 228
    7.5.2. Collecting Community Data 233
    7.5.3. Achieving a Common Vision 235
    7.5.4. Encouraging Shared Values 236
7.6. Phase 3--"Planting the Seeds" 237
    7.6.1. Choosing an Organizational Structure 238
    7.6.2. Defining Program Goals and Objectives 239
    7.6.3. Tensions Related to HSMM's Emphasis on Nutrition 241
    7.6.4. Identifying and Recruiting Partners 243
    7.6.5. Continuing Community Consultation 247
    7.6.6. Clarifying Roles and Responsibilities 248
7.7. Section 2--Theoretical Constructs 250
7.8. Summary 251
    7.8.1. Phase 1--"Preparing the Earth" 251
    7.8.2. Phase 2--"Planning the Garden" 252

7.8.3. Phase 3--"Planting the Seeds" 253

CHAPTER 8: COALITION BUILDING AND ADVOCACY IN HSMM 255

8.1. Introduction 255

8.2. Section 1--An Overview of Coalition and Advocacy 256

8.2.1. Sphere of Coalition Building and Advocacy 256

8.2.2. Coalition Building and Advocacy Defined 257

8.3. Phase 4--"Nourishing and Maintaining the HSMM Garden" 257

8.3.1. Generating Broad Community Participation 258

8.3.2. Maintaining a "Crop" of Community Dietitians 260

8.3.3. "Nourishing the HSMM Garden" 261

8.3.4. Providing a System for Monitoring Feedback 264

8.3.5. Establishing a Positive Organizational Climate 270

8.4. Phase 5--"Harvesting the Stories" 272

8.4.1. Messages of Hope 273

8.4.2. It Works--HSMM Works! 274

8.4.3. Strengthening Partnerships 275

8.4.4. Importance of an Ongoing Recruitment Plan 278

8.4.5. Stories of Personal Learning 280

8.4.6. Dreams for the Future 281

8.5. Future Challenges 283

8.6. Political Action in HSMM 285

8.7. Section 2--Theoretical Constructs 287

8.8. Summary 290

CHAPTER 9: INTERDISCIPLINARY COLLABORATION IN HSMM 293

9.1. Introduction 293

9.2. Section 1--An Overview of the HSMM Teams 295

9.2.1 Sphere of Intersectoral Action 295

9.2.2. Definition of Intersectoral Action 296

9.2.3. Introducing the HSMM Teams 297

9.3. Breaking New Ground 298

9.4. Growing Pains 306

9.5. Supporting Each Other 316

9.6. Issue of Time 322

9.7. Importance of Team Planning 323

9.8. Lessons Learned 324
9.9. Section 2--Theoretical Constructs 329
    9.9.1. Intersectoral Action for Health 329
9.10. Summary 330
CHAPTER 10: THE EMERGING ROLE OF THE COMMUNITY DIETITIAN IN HSMM 333
10.1. Introduction 333
10.2. Section 1--The Evolving Role of the Community Dietitian 335
    10.2.1. Intersectoral Action 335
    10.2.2. Confusion in Terminology 335
    10.2.3. The Generic Role of the Community Dietitian 338
10.3. One Perspective on the Role of the CPNP-Dietitian 339
10.4. HSMM's Community Dietitians in Action 341
10.5. Using Food to Get to Nutrition 349
10.6. Gestational Diabetes: A Case in Point 354
    10.6.1. Application of an Integrated Model of Community Health Promotion 357
        10.6.1.1. Illness Care 358
        10.6.1.2. Illness/Disease Prevention 358
        10.6.1.3. Health Promotion 359
10.7. Contribution of HSMM's Food Preparation Volunteers 360
10.8. Section 2--Theoretical Constructs 368
    10.8.1. Moving Dietetic Practice Upstream 368
    10.8.2. Understanding Critical Theory 369
    10.8.3. The Need for Alternative Perspectives 370
10.9. Summary 370
CHAPTER 11: CONCLUSIONS AND RECOMMENDATIONS 374
11.1. Introduction 374
11.2. Overview of the Study 375
11.3. Major Findings 378
11.4. The Empowerment Holosphere in HSMM 383
11.5 Major Themes 385
    11.5.1. HSMM's "Kitchen Table" Approach 385
    11.5.2. The Empowerment of Participant Women 387
    11.5.3. HSMM's Peer Outreach Workers: Bridging the Gap 388

11.5.4. Community Organization in HSMM 388
11.5.5 Coalition Building and Advocacy in HSMM 389
11.5.6. Interdisciplinary Collaboration 390
11.5.7. The Emerging Role of the Community Dietitian in HSMM 391
11.6. Recommendations for Practice 393
11.6.1. Recommendations on Planning, Implementing, and Evaluating Community-Based Programs 393
11.6.2. Recommendations on Dietetic Practice 395
11.6.3. Recommendations on Funding 396
11.6.4. Recommendations on Dietetic Education and Training 398
11.7. Recommendations for Future Research 398
11.8. Personal Reflections 399
REFERENCES 401
APPENDIX A: NATIONAL CPNP EVALUATION FRAMEWORK 418
APPENDIX B: HEALTHY START FOR MOM & ME DEVELOPMENTAL MODEL 422
APPENDIX C: HEALTHY START FOR MOM & ME COLLABORATIVE MODEL 424
APPENDIX D: INFORMATION LETTER AND CONSENT FORM--PARTICIPATION OBSERVATION 426
APPENDIX E: INFORMATION LETTER AND CONSENT FORM--TRAINED FACILITATOR OF FOCUS GROUPS 431
APPENDIX F: INFORMATION LETTER AND CONSENT FORM--FOCUS GROUP INTERVIEWS 435
APPENDIX G: CONSENT FORM--TRANSCRIPT RELEASE 440
APPENDIX H SEMISTRUCTURED INTERVIEW GUIDE--FOCUS GROUP 442
APPENDIX I INFORMATION LETTER AND CONSENT FORM--INDIVIDUAL INTERVIEWS WITH PROGRAM STAFF AND COMMUNITY PARTNERS 445
APPENDIX J SEMISTRUCTURED INTERVIEW GUIDE--PROGRAM STAFF AND COMMUNITY PARTNERS 448
APPENDIX K INFORMATION LETTER AND CONSENT FORM--ELITE INTERVIEWS 451
APPENDIX L SEMISTRUCTURED INTERVIEW GUIDE--ELITE INTERVIEWS 454

List of Tables

Table Page

2.1. Guidelines for Gestational Weight Gain Ranges 23

4.1. Pseudonyms, Context of Interview, Position, Affiliation, and Approximate Exposure to HSMM 105

10.1. Community to Individual: Gestational Diabetes Mellitus (GDM) 357

List of Figures

Figure Page

2.1. Community Organization and Community-Building Typology 38

2.2. Integrated Model of Community Health Promotion 43

2.3. The Empowerment Holosphere 46

2.4. Powerlessness and Empowerment 54

2.5. Nursing Education Model Based on Social Support 62

4.1. HSMM's "Kitchen Table" Approach 103

4.2. The Empowerment Holosphere in HSMM 142

5.1. The Empowerment Holosphere in HSMM (Personal Care) 147

6.1. The Empowerment Holosphere in HSMM (Small Group Development) 180

7.1. The Empowerment Holosphere in HSMM (Community Organization) 218

8.1. The Empowerment Holosphere in HSMM (Coalition Building and Advocacy) 256

9.1. The Empowerment Holosphere in HSMM (Intersectoral Action) 295

10.1. The Empowerment Holosphere in HSMM (Intersectoral Action) 335

11.1. HSMM's "Kitchen Table" Approach 379

11.2. The Empowerment Holosphere in HSMM 383

CHAPTER 1

OVERVIEW OF THE STUDY

1.1. Introduction

This thesis outlines the purpose, objectives, and contributions of a case study of Healthy Start for Mom & Me (HSMM)--a collaborative, multi-faceted prenatal nutrition program targeting high-risk women and teens in Winnipeg, MB. HSMM is funded by Health Canada (Canada Prenatal Nutrition Program) with contributed staffing and resources from a variety of service partners. The sponsor of the program is Dietitians of Canada (DC). The researcher has organized the content of this thesis into 11 chapters summarized below.

Chapter 1 includes an introduction to the research and provides an overview of at-risk population groups and lifestyle issues related to poor birth outcomes. The aims and purpose of this case study, and the ten specific research questions, are identified.

Chapter 2 summarizes the related literature and highlights the current state of knowledge in some areas relevant to the case study. The content of Chapter 2 focuses on the theoretical foundations underpinning health promotion practices at the community-level. The theory serves to shape the context of the case study on HSMM and its findings.

Chapter 3 describes the method used in the study, the case study design, the processes for analysing data, the assumptions, delimitations and limitations. Additionally, techniques for ensuring the trustworthiness of the data are presented.

Chapters 4 through 10 present the findings of the research pertaining to the functioning of HSMM, primarily through the experiences of participant women, program staff, community partners, and key representatives of the broader community.

The final chapter presents an overview of the case study, a summary discussion of the findings, general themes, implications, recommendations for practice and further research, and personal reflections.

1.2. Rationale for the Study

Babies born with low birth weight (LBW) (less than 2,500 g) are born either preterm (less than 37 completed weeks gestation) or small for gestational age (SGA) (less than 10th percentile for gestational age) or both. There is increasing recognition that the underlying mechanisms for the two causes of LBW are different. It is significant, however, that some risk factors are common to both. While some medical researchers have called for separate approaches to dealing with the two issues, practitioners maintain that from a primary prevention perspective there are valid reasons to address both conditions together (Perinatal Education Program of Eastern Ontario, 1998).

The weight of infants at birth is a principal determinant of both their survival and their health in childhood (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999b). Studies have found that preterm LBW babies have higher rates of health problems in the first few weeks of life including severe respiratory problems (Moutquin, 1996). They also have a higher rate of childhood health problems related to perinatal health concerns (Saigal, 1994). According to Moutquin (1996), 12 to 18% of preterm LBW babies will develop disabilities including cerebral palsy and learning difficulties. There is increasing evidence that the negative effects of low birthweight manifest themselves later in life. For example, a study in Britain using longitudinal data on men born between 1911 and 1930 found those with the lowest weight at birth, and at one year of age, had the highest premature death rate from ischemic heart disease (Barker, 1995).

The high costs of care for low birthweight babies were estimated to be from $500 to $1,000 per day in Canada (Health Canada, 1994b, p. 1). These costs did not take into account the long-term emotional and financial costs for families, the health care system, the education system, and society in general. An American study (Lewit et al., 1995) analysed 1988 national survey data for children ages 0 to 15 and estimated the direct incremental costs of low birthweight--costs of the resources used to care for low birthweight infants above and beyond those used for infants of normal birthweight. According to Lewit et al. (1995), "in 1988, health care, education and child care for the 3.5 to 4 million children ages 0 to 15 born low birthweight cost between $5.5 and $6 billion more than they would have if those children had been born normal birthweight" (p. 1).

There is increasing evidence that traditional approaches to prenatal health promotion have not been successful in reducing the incidence of low birthweight in Canada (Kramer, 1998). Additionally, policy makers have expressed concern that the high costs associated with the medical treatment of low birthweight infants continue to rise (The Canadian Institute for Advanced Research, 1999). The controversy over the effectiveness of prenatal care in preventing LBW, stems from difficulties in defining the constituents of adequate prenatal care. The collective evidence regarding the efficacy of prenatal care to prevent low birthweight is mixed. However, Alexander and Korenbrot's (1995) literature review suggested that the most likely known targets for prenatal interventions to prevent LBW were "psychosocial (aimed at smoking), nutritional (aimed at low pre-pregnancy weight and inadequate weight gain), and, medical (aimed at general morbidity)" (p. 1). The authors called for systems-level approaches to impact the accessibility and the appropriateness of prenatal health services to entire groups of women. Additionally, they concluded that population-wide health promotion, social service, and case management approaches could also offer potential benefits. Alexander and Korenbrot (1995) cautioned that data linking the effectiveness of these services to improved birth outcomes were lacking. They questioned "whether interventions focused on building cohesive, functional communities can do as much, or more, to improve low birthweight rates as individualized treatments" (p.1).

Hughes and Simpson (1995) concurred with Alexander and Korenbrot and suggested that reducing persistent disparities in LBW rates required several steps including embracing a broader definition of health--one which incorporates social dimensions. Hughes and Simpson argued for reshaping the focus of research and interventions from pregnancy outcomes and infant health exclusively to include a more global definition of women's health. According to the authors, "this involves expanding the research agenda to unravel the paradox of socio-economic factors and health and pursue a dedicated national commitment to ensuring adequate support to individuals and their families including both adequate income and health care" (p. 1).

1.3. At-Risk Groups and Lifestyle Issues Related to Poor Birth Outcomes

LBW infants are not a homogeneous group. Despite an extensive amount of research, there continues to be little conclusive evidence about the underlying mechanisms of either preterm birth or SGA (Perinatal Education Program of Eastern Ontario, 1998; Alexander & Korenbrot, 1995; CICH, 1993). This has been a major obstacle in the prevention of LBW. However, evidence presented in Chapter 2 (Section 2.2) supports a relationship between certain maternal conditions, (e.g., socioeconomic status), and behavioural factors (e.g., smoking) and LBW. Despite qualitative and quantitative differences in the etiology of LBW, researchers have identified factors that overlap as predictors of both preterm birth and SGA. Maternal risk factors for both conditions, identified by studies in developing and developed countries, include "age, marital status, education, race, history of previous LBW or other obstetrical complications, smoking, nutritional status, stress, alcohol and other substance abuse, low socioeconomic status, work, multiple gestation, and the lack of prenatal care" (Perinatal Education Program of Eastern Ontario, 1998, p. 11).

Kramer (1987) stated that the prevention of LBW should focus on conditions and factors of risk that are amenable to change, or modifiable. Many of the known risk factors associated with LBW, such as socioeconomic status, ethnicity, genetic makeup, and obstetric history, are not within a woman's immediate control (Chomitz et al., 1995). However, there is strong evidence that lifestyle behaviours such as cigarette smoking, weight gain during pregnancy, and the use of alcohol and drugs play a critical role in determining fetal growth and development. The literature reviewed in Chapter 2 (Section 2.2) summarizes the risk factors that may influence maternal and infant health directly (in terms of physiology), or indirectly (in terms of health behaviour). The focus of the literature review is primarily on lifestyle behavioural risk factors that are amenable to change and that, if modified during the periconceptual or prenatal period, can improve the likelihood of a woman delivering a full-term infant of normal birthweight.

1.4. Background to Study

1.4.1. The Canada Prenatal Nutrition Program—An Overview

In 1996, 5.8% of all live births in Canada resulted in low birthweight babies (less than 2500 g at birth). This represented a total of 21,025 babies (Statistics Canada, 1998). The Canadian low birthweight rate of approximately 6% has not decreased appreciably since the mid-1980s and remains higher than that of Finland, France, Norway, Sweden, and Switzerland (United Nations, 1992). Additionally, the rate of premature birth in Canada has increased by almost 10% in the past decade (Health Canada web site. [December 1, 2000]. Available: http://www.hc-sc.gc.ca/english/archives/releases/preterm.htm).

On July 26, 1994, the Federal Government approved the Canada Prenatal Nutrition Program (CPNP), one of the programs referenced in Creating Opportunity, the Liberal Party's "Red Book." Barrington and Glacken (1998a) described the CPNP as

> a broad, flexible health promotion program that assists communities in developing or improving programs for at-risk pregnant women. Its goals are to improve birth outcomes by decreasing the frequency of low birthweight, increasing the health of both infant and mother and encouraging breastfeeding. The community-based projects provide food supplementation, nutrition counselling, support, and referral prenatally and for up to six months postpartum. There are a number of target groups identified for assistance from CPNP. These include pregnant women (or teens), living in poverty, or who drink or take drugs, live in violent situations, live in isolation or have poor access to services, are diagnosed with gestational diabetes, or who are either Status First Nations women living on or off reserves, Inuit or refugees. (p. 1)

Women participating in CPNP projects across Canada present risk factors for the healthy development of both mother and infant. Of all CPNP participants, 44% are smoking on entry to the program; 38% are 19 years or younger; 24% report a pre-pregnancy Body Mass Index (BMI) of less than 20; 40% of participants have less than grade 10 education; and, 46% of participants report a household monthly income of $1000 or less (Barrington & Glacken , 1998a).

1.4.2. CPNP Intended Outcomes

While the primary aim of the CPNP is to reduce the incidence of low birthweight, the global expected outcomes were described in the CPNP Guide for Applicants (Health Canada, 1999a) as follows:

1. Increased number of babies born over 2500 g (5 lb. 8 oz.);
2. Improved health of pregnant woman (e.g., increased ability to manage stress; reduced negative effects to the mother and infant due to substance abuse);
3. Increased partnership and collaboration among at-risk pregnant women, families, community groups, nutritionists, health professionals and governments;
4. Increased numbers of mothers breastfeeding their babies, and breastfeeding for longer periods;
5. Improved knowledge among at-risk pregnant woman about pregnancy;
6. Increased empowerment to make healthy lifestyle choices. (p. 3)

1.4.3. CPNP Guiding Principles

The CPNP Guide for Applicants (Health Canada, 1999a), provided applicants with the following guiding principles of the program:

- Mothers and Babies First--The health and well being of the mother and baby are most important in planning, developing and carrying out every program;
- Strengthening and Supporting Families--Parents have the main responsibility for the care and development of their children. However, all parts of Canadian society, agencies, employers, organized labour, educators, voluntary community organizations and governments share the responsibility for children by supporting parents and families;
- Equity and Accessibility--Programs are to be sensitive to the cultural and linguistic diversity of Canadian families;
- Partnerships--Partnerships, including parents, families, communities, governments and service providers are essential to develop effective and co-ordinated prevention and early intervention programs;
- Community-based--The community is the focus for decision-making and action. Women, families and community groups have a key role in the planning, implementation and evaluation of programs;
- Flexibility--Programs must be flexible so they can respond to different needs in each community and to the changing needs and conditions of women and children in these communities (p. 3).

1.4.4. CPNP Project Components

The CPNP Guide for Applicants (Health Canada, 1999a) identified the following project components strongly associated with successful comprehensive prenatal programs:

- Prenatal food and nutrition supplements recommended by a registered dietitian, physician or community health nutritionist associated with the program;
- Dietary assessment and nutrition counselling;
- Promotion of breastfeeding, healthy infant feeding, and birth planning;
- Skills development (e.g., food preparation, shopping on a budget, parenting, infant feeding);
- Support to improve access to sufficient and nutritious food through community activities such as collective kitchens, community gardens, and food-buying clubs;
- Social supports including counselling, education, and other assistance from professionals, lay family workers or peers, through home visits, drop-in centres and group sessions;
- Support and counselling on lifestyle issues (e.g., substance abuse, stress, tobacco, alcohol, and family violence);
- Preparation for labour and delivery;
- Participation of expectant and new mothers in the planning and delivery of the program. This will ensure the program meets mothers' needs, and is appropriate to the culture and language of participants;
- Linking and referral to other resources, community programs or services (p. 4).

In addition to the "elements of a comprehensive prenatal nutrition program" listed above, the CPNP Guide for Applicants (Health Canada, 1999a) stated that "a registered dietitian or community health nutritionist should be part of the project planning team, and have ongoing input into program delivery and training. In remote areas consultation may be done by telephone, correspondence or site visits" (p. 4).

1.4.5. CPNP National Evaluation Framework

Health Canada contracted Calgary-based Barrington Research Group, Inc. to design a CPNP national evaluation framework, shortly after announcing the program in 1994. "An evaluation framework was envisioned which would incorporate federal, regional and local evaluation needs into one evaluation process to decrease duplication of efforts and reduce costs" (Barrington & Glacken, 1998a, p. 4). The CPNP national evaluation framework is provided in Appendix A.

The CPNP national evaluation design was based on two separate evaluation instruments; one with a program focus, and the other targeting individual clients. A brief description of both instruments follows:

1. Individual Project Questionnaire (IPQ)--a mandatory survey, completed by programs across the country on an annual basis, provided a standard series of 28 questions on program-related information. Topics included: "the nature of the project, the type of intervention, pregnancy outcomes (e.g., birthweight), infant and maternal health and breastfeeding rates" (Barrington & Glacken 1998a, p. 6). Additionally, data were collected on community partnerships and collaborations, "spin-offs and lessons learned" (p. 6).
2. Individual Client Questionnaire (ICQ)--a participant-based survey, featured "a bank" of 106 client-centred questions on topics including
   - Client information at entry – demographics and previous pregnancy history;
   - Other client information – client health problems, nutrition assessment and other pre-delivery questions;
   - Risk factor information – tobacco, alcohol, drug use issues;
   - Lifestyle information – issues related to housing, food security, abuse, coping skills, self esteem and support network;
   - Pregnancy outcomes – birth weight, maternal and infant health;
   - Client information at exit – utilization of project services, breastfeeding information (Health Canada, 2000, p. 3).

Of the 106 questions included in the ICQ "bank," 38 questions were mandated by Health Canada. Additional ICQ questions were selected by provincial and/or regional advisory groups. In some cases, project personnel also requested that specific questions be included on the questionnaire.

As of March 2000, the CPNP national database contained over 13,000 completed ICQs. Additionally, in 1999, 95% of CPNP projects funded by Health Promotion and Programs Branch --280 out of 295 projects--submitted IPQs for inclusion in the IPQ (1998-99) Summary Report. According to the national evaluators, ICQ and IPQ data indicated that CPNP projects are having a positive impact on high-risk mothers and babies" (Barrington Research Group, 2000, p. 1).

1.5. Brief Description of the Case--A CPNP Initiative in Winnipeg

In the fall of 1994, The Manitoba Association of Registered Dietitians (MARD) was asked by Health Canada to sponsor and facilitate the development of a community-based prenatal nutrition program in Winnipeg, under the auspices of the CPNP. At that time, 60% of low birthweight babies in Manitoba were born in Winnipeg. There were high rates of teen pregnancy and child poverty and the stillbirth rate among Aboriginals was three times greater than in the rest of the population (Winnipeg Prenatal Nutrition Initiative Steering Committee [WPNISC], 1996). Furthermore, prenatal services were fragmented and those that were available offered limited, if any, community-based nutrition education. In general, the needs of high-risk pregnant women and teens in Winnipeg were not being met (Barrington & Glacken, 1998b).

The process of developing Healthy Start for Mom & Me (HSMM) began with extensive community consultations held over a six-month period which actively involved members of the target population (Appendix B). Current community-based prenatal programs and services were reviewed, gaps documented, and the following issues identified:

- Many women living in the inner city of Winnipeg and adjacent districts experienced poverty and social isolation on a daily basis. Many women smoked and some reported using drugs or alcohol while pregnant.
- Pregnant teens and women living in poverty typically did not access health services until late in their pregnancies. They did not receive prenatal check-ups at recommended intervals and they did not attend prenatal classes. Fear, denial, distrust of the traditional health care system, lack of transportation, bus fare, and/or childcare arrangements were frequently cited as barriers.
- Marginalized women were typically unable to afford the optimal amount or the variety of food necessary to support a healthy pregnancy. They were often unaware of the type and amount of food they should be eating, and they lacked knowledge of simple recipes and basic food preparation techniques.

The city-wide program was designed to address these issues and "to encourage healthy pregnancy and healthier babies through the provision of social support, basic food and vitamins, promotion and support of breast-feeding, and related informal health education" (WPNISC, 1996, p. 2). The premise of HSMM was that culturally appropriate social support, coupled with community resources and information, would enable high-risk pregnant women to successfully overcome barriers to early prenatal care and encourage their seeking out health and social services for themselves and their families.

1.5.1. Data on HSMM Participants

HSMM statistics on participant women enrolled in the program in 1997-1998 suggested that the program is serving the target group identified in the CPNP funding guidelines:

- Total number of participants 1997 to 1998 – 594; total number of participants 1996 to 1997 – 371;
- Participants breastfeeding on discharge from hospital – 76%;
- Participants stating that Healthy Start for Mom & Me influenced their decision to breastfeed – 38%;
- Participants enrolled in the program before 28 weeks of pregnancy – 65%;
- Teens to age 19 enrolled in the program – 32%;
- Income level of participants (self reported) – 100% low income;
- Participants with less than Grade 12 education – 35%;
- Participants that are single, including separated or divorced – 60% (6% separated or divorced);
- Participants reporting that they are Aboriginal – 37%; Non-aboriginal – 63%; Immigrant/refugee – 4%;
- Participants that are overweight (based on pre-pregnancy weight) – 18%;
- Participants that are underweight (based on pre-pregnancy weight) – 36%;
- Participants that smoke on enrolling in the program – 44% (23% didn't answer the question); participants that cut down on smoking during pregnancy (44%); participants that stopped smoking during pregnancy (27%);
- Participants that drink alcohol on enrolling in the program – 5% (36% didn't answer the question); participants that cut down on drinking during pregnancy (5%); participants that stopped drinking during pregnancy (54%);
- Participants stating that they use food banks – 73%; participants stating that they need to get food from friends or relatives (46%);
- Participant contacts with program (drop-in and outreach) – 35% have more than 10 contacts; participants reporting up to 5 contacts with program (41%);
- Participants reporting that they tried new foods; used Healthy Start for Mom & Me's recipes and other resources – 71%. (Healthy Start for Mom & Me, 1999b, p. 1).

1.6. Purpose of the Study

This study used a qualitative case study approach to describe and to understand a collaborative, multi-faceted, community-based prenatal nutrition program. The purpose of the case study was to describe the dynamics of HSMM operations; to understand the experiences of participant women, staff, and community partners; and to interpret how the program "worked' within a socio-environmental context.

1.7. Major Research Questions

There were three major research questions requiring careful investigation. First, what were the salient themes, patterns, and categories in the meaning structures of participant women, program staff, and community partners? Second, how were these patterns linked with one another? Third, how did these patterns operate within a socio-environmental context? These questions, drawn from the theoretical framework, guided data collection and analysis. In addition to the three general questions, the researcher developed ten specific research questions listed in Section 1.8.

1.8. Specific Research Questions

The specific research questions for this case study were as follows:

1. How were participant women brought into the program and how did they move through the program once they become participants?
2. What were the factors that influenced community partners' decisions to participate in the program?
3. What were the experiences of participant women, program staff, community partners, and key representatives of the broader community in HSMM?
4. What was the nature of the interactions between participant women, program staff and team members contributed from partner agencies and organizations?
5. How had the lives of participant women changed over the period of their involvement in HSMM?
6. What differences had the program made in the inner city communities that it serves?
7. What were the strengths and weaknesses of the program?

8. How had active involvement in the program changed stakeholders' understandings of prenatal health promotion?
9. What issues and tensions had emerged from the program's emphasis on interdisciplinary teams, including the peer outreach workers' practices with marginalized women and their families?
10. How had interdisciplinarity challenged the norms and values of the practitioners' professions?

1.9. Significance of the Study

The Federal Government budget, released February 1999, renewed Health Canada's commitment to the CPNP by allocating $75 million over three years. The funding will be used to enhance existing programs, develop new programs, and strengthen research and public education on Fetal Alcohol Syndrome/Fetal Alcohol Effect, as well as perinatal surveillance (Health Canada web site.[February, 1999]. Available: www.hc-sc.gc.ca/budget).

At the same time as funding has increased, questions have been raised with respect to the effectiveness of the CPNP in reducing the rate of low birthweight in Canada, and in improving birth outcomes. An editorial by Dr. Michael Kramer, published in the September 1988 issue of the Canadian Medical Association Journal, severely criticized the CPNP suggesting that its legacy will be not only wasted money, but also "wasted opportunity and disillusionment over hopes that remain unfilled" (p. 665). The author described the CPNP as a "fundamentally flawed policy of providing milk, eggs and orange juice to poor pregnant women" (p. 665) and concluded that the CPNP will have no perceptible impact on pregnancy outcomes. Dr. Kramer, a well-known Canadian physician-epidemiologist, strongly urged the Federal Government to re-direct funding into more research into biological mechanisms underlying preterm labour, given that preterm labour is a particularly important and not well understood public health problem.

Increasingly, both qualitative and quantitative data are necessary to assist policy makers in documenting outcomes, re-shaping program goals and objectives, and demonstrating the cost-effectiveness of the CPNP. HSMM is participating in a national CPNP evaluation, administered on a project-by-project basis, across the country. While program staff were involved in the development of the highly quantitative research tool, participants were not. Staff have expressed a need and a desire to personalize the evaluation process by using research methods that emphasize personal, face-to-face contact with the program. Methods have been called for that do not label and number the participants and may be perceived as "humanistic" because they feel natural, informal, and understandable to participants (G. Wylie, personal communication, January 1999). The rich qualitative data from the case study on HSMM added depth, detail, and meaning on a project specific basis. The data complemented the statistical findings and survey generalizations used to track the general health of pregnant women participating in CPNP projects across the country.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

There is a paucity of international and national literature on qualitative approaches to describing and evaluating community-based prenatal nutrition interventions. Thus, a review of related literature in the fields of medicine, clinical and/or community nutrition, health promotion/education, and population health reinforced the need for this study and illustrated how this study complemented previous research done in related areas. The sources reviewed fall into three general areas: Biomedical and/or nutritional literature focusing on at-risk groups and lifestyle issues related to poor birth outcomes; prenatal health promotion literature; and other related health promotion/education literature. The review of related health promotion/education literature focuses on broad theoretical constructs pertaining to social change processes; empowerment education; the concept of "cultural brokerage" (Jezewski, 1995, p. 20); interdisciplinary collaboration; social support; community development, food security, and; socio-environmental approaches to health promotion.

2.2. Overview of At-risk Groups and Lifestyle Issues Related to Poor Birth Outcomes

A primary source of information for the review is Nutrition for a Healthy Pregnancy: National Guidelines for the Childbearing Years (Health Canada, 1999b). In drafting the guidelines, Health Canada relied heavily on an American publication: National Academy of Sciences, Institute of Medicine, Food and Nutrition Board, Committee on Nutritional Status during Pregnancy and Lactation, Subcommittee on Dietary Intake and Nutrient Supplements During Pregnancy, Subcommittee on Nutritional Status and Weight Gain during Pregnancy. Nutrition During Pregnancy. 1990. Part 1 – Weight Gain. Part 11 – Nutrient Supplements. Washington. DC.

2.2.1. Adolescent Pregnancy

About half of Canada's teens (aged 15 to 19) are sexually active, and approximately 25% of them do not use birth control (Canadian Institute of Child Health, 1994). In 1995, there were 38,502 teenage pregnancies (including live births, abortions and stillbirths) in Canada. The number of teenage pregnancies decreased among 15- to 19-year-olds from the mid-1970s to 1988, and then increased slightly. The Progress of Canada's Children Report (1998) stated that "while the number of teen pregnancies in 1995 was still well below their historic highs, increasing rates of teen pregnancies (from 41 per 1,000 women aged 15 to 19 in 1987 to 47 per 1,000 in 1995) is a worrisome trend" (p. 39). The low birthweight rate of 7%, among teens aged 15-19, was more than a full percentage point higher than the Canadian average of 5.8% (Statistics Canada, 1998).

The dietary practices of teens that contribute to low energy and nutrient intakes--especially with respect to calcium and iron--do not provide adequate energy and nourishment to promote a healthy pregnancy outcome (American Dietetic Association, 1994). Additionally, adolescent pregnancies occurring within two to three years of menarche are considered high-risk given that the nutritional needs of the pregnancy and developing fetus take precedence over those of the teen mother's own growth (American Dietetic Association, 1994).

The mother's pre-pregnancy weight, relative to her height (i.e., Body Mass Index [BMI]) is a determinant of fetal growth and gestational maturation (Kramer, 1987). BMI is not recommended as a tool to assess the weight status of adolescents, however, it may be used with expectant teens who are at least two years post-menarche to determine appropriate prenatal weight gain recommendations (National Academy of Sciences, 1990). Women with a low pre-pregnancy BMI tend to have smaller babies than do heavier women with the same gestational weight gain. To optimize fetal growth, the U.S. Institute of Medicine (IOM) recommended that pregnant adolescents aim for the higher-end of the weight-gain range of their pre-pregnancy category (Health Canada, 1999b). Insufficient gestational weight gain for pre-pregnancy BMI is associated with increased risk for low birthweight (Kramer, 1987; National Academy of Sciences, 1990).

> Nutrition for a Healthy Pregnancy (Health Canada, 1999b) guidelines stated that
>
> pregnant adolescents should receive early, frequent and continuous nutritional care (American Dietetic Association, 1994) in a comprehensive program setting (Health Canada, 1998) that is easily accessed and designed to meet the unique needs of this at-risk group. (p. 64)

2.2.2. Smoking

"Maternal smoking and/or considerable exposure to environmental tobacco smoke during pregnancy increases the likelihood of a premature delivery and the birth of a low-weight baby who is at high risk for disabilities" (Federal, Provincial, and Territorial [F/P/T] Advisory Committee on Population Health, 1999b, p. 160). According to Single et al. (1995), the infants of Canadian women who smoke during pregnancy are one-and-one-half times more likely to be of low birthweight compared to infants born to non-smokers.

In 1996-97, about 36% of new mothers, who were former or current smokers, acknowledged smoking during their most recent pregnancy (Statistics Canada, 1998). These mothers indicated that they smoked an average of nine cigarettes a day while pregnant. The prevalence of smoking while pregnant, in Canada, was closely linked to education. The 1996-97 National Population Health Survey reported that among women who had ever smoked, 61% of pregnant women with less than a high school education smoked during their pregnancies, compared to 14% of women with a post-secondary education. Additionally, 40% of teen mothers in Canada smoked during their pregnancies. In comparison to women aged 25 and older, the pregnant teen population was twice as likely to smoke.

Data presented in Toward a Healthy Future: Second Report on the Health of Canadians (F/P/T Advisory Committee on Population Health, 1999b) provided additional insight into teen smoking and the relationship to low birthweight:

> Teen mothers who smoke and have low levels of education are more likely to have a low birthweight baby, but no more so than older mothers who smoke and have comparable levels of education. Thus, it appears that income and education--not age--are the major predictors of smoking in pregnancy (p. 77).

Nutrition for a Healthy Pregnancy (Health Canada, 1999b) guidelines suggested that smoking may adversely affect nutritional status. According to Preston (1991), "the rise in metabolic rate associated with smoking, and the antagonistic interaction between certain nutrients and tobacco smoke constituents, compounds the risk of inadequate nutrient consumption" (p. 67). Keen and Zidenberg-Cherr (1994) hypothesized that smokers may require higher intakes of vitamins B6, B12, C and E, folate, B-carotene, selenium, and sulphur amino acids than non-smokers. Women who continue to smoke while pregnant may well require even higher intakes of these nutrients.

2.2.3. Alcohol Abuse

"Canadian women who drink during pregnancy tend to be older and of higher socioeconomic status than non-drinkers" (F/P/T Advisory Committee on Population Health, 1999b, p. 77). In the 1996-97 National Population Health Survey, the vast majority of women reported that they did not drink during their pregnancy. Only 2.5% of those that drank alcohol during their pregnancy reported that they had consumed at least five drinks "at one time," and 7% reported drinking throughout their entire pregnancy (Statistics Canada, 1998).

Although the effect of alcohol-related damage varies with the amount consumed during pregnancy, the consequences can lead to long-term disabilities in the form of alcohol-related birth defects. Such defects have been described following heavy intake of alcohol during pregnancy. However, intermittent or binge drinking has also been linked to fetal alcohol syndrome (FAS) and fetal alcohol effect (FAE) (Health Canada, 1999b).

Although there are no Canadian incidence data available on FAS/FAE, it is estimated that one in every 1000 children born in industrialized countries has FAS (Quinby and Graham, 1993). Nutrition for a Healthy Pregnancy (Health Canada, 1999b) guidelines stated that, "this estimate might be conservative, however, because FAS/FAE are not easily identified at birth, the condition often goes undetected, or is confused with other health problems" (p. 70). Case studies of specific Aboriginal communities have suggested that FAS is more prevalent among Canadian Aboriginal children, than non-Aboriginal children. However, the authors of Toward a Healthy Future: Second Report on the Health of Canadians (F/P/T Advisory Committee on Population Health, 1999b) stated that, "there is yet no good evidence to support this conclusion"(p. 160).

The children of women who continue to drink an average of greater than one drink per day daily throughout their pregnancies are significantly smaller, shorter, and have smaller head circumferences than infants of control mothers who stop drinking (Day et al., 1989). The risk of LBW to women drinking three to five drinks per day was increased twofold over non-drinking mothers and almost threefold for those drinking six or more drinks, compared with women who did not drink (Mills et al., 1984). While the effects of heavy daily drinking are well documented, the impact of moderate drinking on birth outcomes is not as well-established (Chomitz et al. 1995).

2.2.4. Illicit Drug Use

Generally, the reported use of illicit drugs in Canada is low: in 1994-95, less than 1% of Canadians reported using crack cocaine, LSD, or speed on the National Population Health Survey (Statistics Canada, 1998). However, 7% of Canadians (1.7 million people) indicated that they used marijuana. The use of illicit drugs in Canada was highest among youth, and especially among those with some post-secondary education (F/P/T Advisory Committee on Population Health, 1999b).

In recent years, the rise in use of illegal drugs in the United States, particularly prenatal drug and cocaine or "crack" has sparked many investigations. Prenatal cocaine and heroin abuse is clearly associated with adverse birth outcomes. According to Chomitz et al. (1995), "other factors in a drug addict's lifestyle including malnutrition, sexually transmitted diseases, and polysubstance abuse may contribute to an increased risk of adverse pregnancy outcome, and often complicate the ability to examine the effects of individual drugs" (p. 7). Information on the effect of marijuana use on the health of women and their infants is lacking. Additionally, the effects of the occasional use of cocaine and other drugs in pregnancy are not clear.

2.2.5. Socioeconomic Status

Poverty is a growing concern in Canada. Between 1990 and 1995, the proportion of Canadians with low-income status increased from 16% to 20%, but certain groups in the population were more adversely affected than other groups (F/P/T Advisory Committee on Population Health, 1999b). In 1995, children (under the age of 6), youth (aged 18 to 24), and unattached seniors (primarily women) were the most likely to be classified as low-income.

In 1995, almost 50% of single-parent mother-led families were in low-income situations. However, recent data suggest that poverty was not restricted to single-parent families. From 1990 to 1995, the percentage of married couples with children in low-income situations rose from 9.5% to 13%. An estimated 1.3 million Canadian children under the age of 15 lived in low-income households in 1995--an increase of 300,000 children in only five years (F/P/T Advisory Committee on Population Health, 1999b).

Achieving food security is a challenge faced by an increasing number of low-income Canadians. In 1996-97, 6% of Canadians reported that, at some point during the previous year, their household had "run out" of money and could not afford to buy food. Of these, 27% said that they had received food from a food bank, soup kitchen, or other charitable agency, and 62% said that they did not always have enough to eat (F/P/T Advisory Committee on Population Health, 1999b). Among single parents, 18% of women, and 8% of men, reported that they had "run out" of food at least once during the previous year. A 1998 report, produced by the Canadian Association of Food Banks, indicated that the number of Canadians using food banks more than doubled between 1989 and 1998. Additionally, the report stated that the number of communities with food banks more than tripled during that time (Edmonton Journal, October 17, 2000, A12).

For some time, it has been known that the incidence of poor perinatal outcomes (including LBW) is significantly higher in lower socio-economic classes (National Council of Welfare, 1997). These discrepancies are even more pronounced in sub-populations of the very poor, such as the inner-city neighbourhoods of Montreal and Toronto where low birthweight rates are as high as 10%--rates that are similar to those in developing countries. In Winnipeg, the 1993-94 percentages for LBW babies were 4.5% for the entire city, as compared to 8.5% in inner-city neighbourhoods (average) and 15.5% in the inner-city neighbourhood of North Point Douglas (Healthy Start for Mom & Me, 1998).

Research in Manitoba demonstrated a strong relationship between income level of the mother and her baby's birthweight (F/P/T Advisory Committee on Population Health, 1994). The effect occurred not just for the most economically disadvantaged group.

Mothers at each step up the income scale had babies with higher birthweights, on average, than did those mothers on the step below. This finding suggested that the problems were not just those such as poor maternal nutrition and poor health practices most likely to be associated with at-risk groups. While the authors acknowledged that the most serious problems occurred in the lowest income group, they suggested that factors such as "coping skills, sense of control and mastery over life's circumstances, with their attendant biological pathways, also came into play" (p. 23).

Chomitz et al. (1995) hypothesized that economic disadvantage may be a risk factor for low birthweight partly because of the high levels of stress and negative life events associated with being poor. Both physical stress and fatigue--particularly related to work during pregnancy--and psychological distress have been implicated. In addition, stress and negative life events were associated with health behaviours such as smoking (Health Canada, 1995). Mustard and Frank (1991) suggested that social support may act as a moderator, or as a buffer, from the untoward effects of stressful life experiences and emotional dysfunction (F/P/T Advisory Committee on Population Health, 1994).

2.2.6. Health Status Disparities (Aboriginals and Recent Immigrants)

Some groups of Canadians have significantly lower health status than others. This lower health status is primarily associated with their very low income, socio-economic status, lack of education, and other unfavourable living conditions. Also, women on average tend to have lower incomes and occupational status and face considerable stresses in balancing the demands of work and family life. "The potential negative effects of these factors on women's health were intensified for women living in disadvantaged circumstances, for example, aboriginal and immigrant women" (F/P/T Advisory Committee on Population Health, 1994, p. 26).

Canada's Aboriginal peoples, as a group, are the most disadvantaged and have the poorest health status (Health Canada, 1996). Registered Indians and Inuit have significantly higher infant death rates than does the total Canadian population. Although the gap in infant mortality between Aboriginal peoples and other Canadians has narrowed in recent years, it is still significant. In 1994, the infant mortality rate was twice as high among First Nation people than in the Canadian population as a whole (F/P/T Advisory Committee on Population Health, 1999b). The neonatal mortality rate (i.e., infant death occurred within the first 7 days of life) was close to the national average. However, "infant mortality rates during the postneonatal period were at least three times higher among First Nations infants than in the general population, and stillbirth rates were also higher" (p. 76).

The rate of low birthweight among Canada's Aboriginal population in 1997-97 did not differ significantly from national norms in 1994-95. However, the rate of high birthweight (above 4000 g) was significantly higher (i.e., 18% versus 12%). According to the authors of Toward a Healthy Future: Second Report on the Health of Canadians (F/P/T Advisory Committee on Population Health, 1999b), "high birthweight is associated with higher neonatal mortality" (p. 76).

Food insecurity caused by low income, high food costs, concern about the safety of traditional foods, and lack of access to nutritious foods puts some Aboriginal women at risk of poor nutrition (Statistics Canada, 1993). The Aboriginal Peoples Survey (1991) (Statistics Canada , 1993) indicated that 8% of all respondents over 15 years of age experienced food availability as a problem the proceeding year. The survey report stated, in total, 8% of all Indians living on reserve and 9% of Indians living off reserve reported food availability as a problem.

Cultural practices, and social or religious beliefs, can significantly restrict food choices during pregnancy. Recent immigrants--especially those claiming refuge status--may be at risk of poor nutrition (Health Canada, 1999b). New immigrants, depending on their circumstances, may not have a source of familiar foods and may lack experience preparing and serving local foods. In this case, food insecurity has been partly attributed to a lack of familiarity with the public transportation system, the location of markets, grocery stores, and other services (Health Canada, 1999b).

2.2.7. Family Violence

Women and children are more often victims of family violence in Canada, than are men. In 1993, approximately one-third of Canadian women over the age of 16 reported violence at the hands of an intimate partner at some point during their lives (Statistics Canada, 1993). A 1998 report, prepared by the Canadian Centre for Justice Statistics, states that "four out of five women and children living in shelters or transitions centres in 1995 were there to escape an abusive situation, the majority from abuse by a partner (or father)" (p. 61).

Although there is limited scientific research linking the negative effects of family violence to the nutritional status of Canadian pregnant women, American research has reported a significantly higher percentage of low birthweight deliveries in abused women (Bullock and McFarlane, 1989). Statistics Canada data (1994a) reported that 21% of the women surveyed in a national study on violence, who had been abused by a current or previous partner, were assaulted during pregnancy. Slightly under half of these women indicated that the abuse began during pregnancy. Additionally, the survey found that close to 10% of women injured by their spouses experienced adverse perinatal outcomes, including internal injuries and miscarriages.

The Statistics Canada Survey (1994b) stated that 25% of Canadian women who reported that they had lived with violence said that they had turned to alcohol, drugs, or medication to help them cope with their situation. The potential of these substances to adversely affect birth outcomes is well documented.

2.2.8. Gestational Weight Gain and Maternal Nutrition

Concerns about nutrition and pregnancy fall into two basic areas: (a) gestational weight gain and (b) nutrient intake, both of which can potentially affect the health of the mother and infant. As with other lifestyle factors, a woman's food choices and weight gain are closely related to her socioeconomic status, cigarette smoking, and other health-related behaviours (Chomitz et al., 1995).

Maternal weight gain during pregnancy results from a variety of factors including maternal dietary intake, pre-pregnancy weight and height, length of gestation, and size of the fetus. Chomitz et al. (1995) stated that "the relationship between a woman's caloric intake during pregnancy and her infant's weight is complex and is moderated through maternal weight gain and other mechanisms during pregnancy" (p. 3).

2.2.8.1. Gestational Weight Gain

Women who do not gain enough weight during pregnancy may deliver a low birthweight baby (National Academy of Sciences, 1990). Nutrition for a Healthy Pregnancy (Health Canada, 1999b) guidelines stated that "poverty, youth, a limited support network, physical abuse, low educational level, severe nausea/vomiting, excessive dieting and eating disorders have been associated with insufficient gestational weight gain" (p. 51).

Excessive gestational weight gain may be associated with high birthweight, defined as more than 4000 g (8.8 lb.) (National Academy of Sciences, 1990). Poor birth outcomes associated with high birthweight include prolonged labour, birth trauma, birth asphyxia, caesarian birth, and increased risk of perinatal mortality (National Academy of Sciences, 1990). The lowest risk of infant mortality is associated with birthweights of 3500 to 4000 g (7.7 to 8.8 lb.) (Saugstad, 1981).

Current Canadian recommendations suggest weight gain ranges be based on the mother's pre-pregnancy BMI (Health Canada, 1999b). These recommended weight gain ranges reflect observations of healthy pregnancy outcomes. They promote a slightly different range of weight gain for each of the three BMI categories as shown in Table 2.1.

Table 2.1
Guidelines for Gestational Weight Gain Ranges

BMI category	Recommended total gain Kg	Recommended total gain lb.
BMI < 20	12.5 – 18.0	28 – 40
BMI 20 – 27	11.5 – 16.0	25 – 35
BMI > 27	7.0 – 11.5	15 – 25

(Adapted from the United States Institute of Medicine)
Note: BMI=Body Mass Index
Source: "Gestational Weight Gain" in Nutrition for a Healthy Pregnancy (Health Canada, 1999b), p. 52.

2.2.8.2. Maternal Diet and Nutrient Intake

The physiological changes associated with pregnancy call for additional energy and nutrients to meet the demands of an expanding blood supply, the growth of maternal tissues, and a developing fetus. Additionally, the loss of maternal tissues during birth and maternal preparation for lactation are important considerations when determining prenatal nutrient requirements.

During pregnancy, the nutrients of particular concern include folate; calcium and vitamin D; iron; and essential fatty acids (e.g., linoleic acid and alpha-linolenic acid) (Health Canada, 1999b). Current recommendations urge pregnant women to pay particular attention to their intake of three nutrients--folate, iron and calcium--because there is potential for sub-optimal intakes in some population groups. These three nutrients will be addressed individually, from a prenatal nutrition perspective.

Folate

Data cited in Nutrition for a Healthy Pregnancy (Health Canada, 1999b) indicated that the average dietary folate intake by Canadian women of childbearing age is close to the 1990 Recommended Nutrient Intake (RNI) for non-pregnant women (Nova Scotia Heart Health Program, 1993). Recent data suggested that it may be challenging for expectant women to achieve their recommended folate intake strictly from dietary sources (Health Canada, 1999b).

O'Connor (1995) stated that high-risk groups for sub-optimal folate intakes included those with poor eating habits; chronic dieters; tobacco, drug, or alcohol users; adolescents; and women of low socio-economic status. Present evidence underscores the importance of pregnant women taking a daily supplement containing folic acid during the periconceptual period to reduce the risk of neural tube defects (NTDs) (Werler et al., 1993). Health Canada's guidelines, Nutrition for a Healthy Pregnancy (1999b) recommended that

> women who have not had a previous NTD-affected pregnancy should be advised, in addition to eating a healthy diet according to Canada's Food Guide to Healthy Eating, to take a daily supplement of 400 ug (0.4 mg) folic acid beginning before becoming pregnant and continuing through the early weeks of the pregnancy. (p. 9)

Iron

Canadian nutrition recommendations call for an iron supplement during the second and third trimesters of pregnancy, on the assumption that pre-pregnancy stores are inadequate (Health and Welfare Canada, 1990). Nutrition for a Healthy Pregnancy (Health Canada, 1999b) distinguished between iron deficiency without anemia (i.e., Stage

2), and iron deficiency (i.e., Stage 3), and stated that both conditions are common during pregnancy (p. 30). Iron deficiency anemia has been linked to poor birth outcomes including low gestational weight gain, premature delivery, low birthweight and fetal death (National Academy of Sciences, 1990).

Canadian data reported that the average iron intake of women of childbearing age was below the RNI (Nova Scotia Heart Health Program, 1993). Additionally, teenage girls have been considered a high-risk group for low iron intake (Gibson, 1994) on account of poor eating patterns, and a preference for foods of plant origin containing non-heme iron.

In situations where low iron stores are suspected (i.e., Stage 1), health professionals will prescribe a low-dose iron supplement together with a diet rich in iron (Health Canada, 1999b). Factors that increase the absorption of non-heme iron will also be reviewed with the expectant woman. Should a Stage 2 or 3 iron deficiency be diagnosed, larger doses of iron supplements may be advised to improve prenatal iron status (p. 30).

Calcium and Vitamin D

Canadian data suggested that the average dietary calcium intake of women of childbearing age is lower than the RNIs (Nova Scotia Heart Health Program, 1993). High-risk groups for low calcium intake include pregnant teenagers; vegans; members of some cultural groups; and those living in poverty (Health and Welfare Canada, 1990; Rees and Worthington-Roberts, 1994).

Pregnant and lactating women require both calcium and vitamin D to maintain bone health, while ensuring optimal skeletal development of the fetus, and the production of breastmilk. "Vitamin D increases intestinal absorption of calcium and is essential for the body to use calcium efficiently" (Health Canada, 1999b, p. 32). Should the maternal diet be low in calcium or vitamin D, supplementation may be recommended along with a dietary prescription to increase consumption of calcium and/or vitamin D-rich dietary sources.

Nutrition for a Healthy Pregnancy (Health Canada, 1999b) guidelines stated that "although overt signs of vitamin D deficiency in the general Canadian population are not widespread, those who consume no milk, evaporated or powdered milk, may be at risk for poor vitamin D status " (p. 33). Lebrun et al.'s (1993) study, conducted in a northern Manitoba community, concluded that depleted vitamin D stores in infants and children were the result of limited exposure to sunlight and low milk intake.

Essential Fatty Acids

Nutrition for a Healthy Pregnancy (Health Canada, 1999b) guidelines emphasized that "it is important that pregnant women consume adequate amounts of essential fatty acids (EFAs)--linoleic acid and alpha-linolenic acid--in their daily eating patterns for proper fetal neural and visual development" (p. 35). Al, van Houwelingen, and Hornstra (2000) explained that there are two families of EFAs; the n-6 series and n-3 series. The authors described linoleic acid as "the parent EFA of the n-6 family," and alpa-linolenic acid as "the parent of the n-3 family (p. 285S)." Both "parent" EFAs can be converted in the body to a series of longer chain, more unsaturated EFA's, called long-chain polyunsaturated fatty acids (LCPUFA). Dietary linoleic acid is converted into arachidonic acid (AA), and alpha-linolenic acid is converted into docosahexaenoic acid (DHA). Both LCPUFAs, AA and DHA, are important structural fatty acids in neural tissue and play a critical role in normal fetal development.

During pregnancy, these EFA metabolites accumulate rapidly in fetal and infant neural tissue, especially during the last trimester of pregnancy, and the first few months of postnatal life (Al et al., 2000). To obtain these EFAs, the fetus depends primarily on placenta transfer, and thus on the EFA status and supply of the mother (Innis, 1991). The recommended nutrient intake for EFAs increases during pregnancy to meet the needs of the growing fetus (Health and Welfare Canada, 1990). Nutrition for a Healthy Pregnancy (Health Canada, 1999b) stated that "to achieve the recommended intake, pregnant women should increase their intake of EFAs" (p. 35). To promote adequate EFA intake, expectant women are encouraged to include the following foods in their daily eating pattern: soybean oil, canola oil, non-hydrogenated margarines, soy-based products (e.g., tofu, vegi burger) and salad dressings made from recommended types of oils.

The Dutch researchers Al et al. (2000) questioned whether there is sufficient evidence to recommend that the LCPUFA content of the maternal diet be increased to improve pregnancy outcomes. The authors concluded that long-term follow-up studies with a large cohort of pregnant women and their infants are needed to determine whether

LCPUFA status during pregnancy, at birth, and in early infancy is associated with functional outcome later in life. In the authors' words, "until these data are available, it may be premature to offer recommendations for LCPUFA intake during pregnancy" (p. 290S).

2.2.9. Indicators for Referral to a Nutrition Professional

While most women recognize the importance of healthy eating, some find it particularly difficult to achieve (Canadian Foundation for Dietetic Research, 1997). Groups at particular risk of nutritional inadequacy during pregnancy may require nutrition counselling (Chomitz et al., 1995). These groups include: women voluntarily restricting caloric intake or dieting; pregnant adolescents; women with low income or limited food budgets; women with eating patterns or practices that require balancing food choices (such as strict vegetarians); women with emotional illness; smokers; women with poor knowledge of nutrition due to lack of education or illiteracy; and women with special difficulties in food resource management because of limited physical abilities and poor cooking or budgeting skills (Dwyer, 1983).

2.2.10. Medical Conditions

Chronic diseases can complicate pregnancy and some medical conditions that develop during pregnancy can adversely affect the health of mother and baby. The human immunodeficiency virus (HIV) is of particular concern given that the virus can be transmitted from an infected mother to her fetus. Additionally, Gestational Diabetes Mellitus and pre-eclampsia, which occur during pregnancy, if not detected and not appropriately treated, are associated with fetal and maternal morbidity and mortality.

2.2.10.1. Gestational Diabetes Mellitus

Gestational Diabetes Mellitus (GDM) occurs in an estimated 2% to 4% of pregnancies (Meltzer et al., 1998). Trends indicate a higher prevalence of GDM among First Nations populations (Brassard et al., 1993). Women of Hispanic, Asian or African descent may also be at increased risk (Meltzer et al., 1998). GDM is associated with an increased risk of fetal macrosomia, neonatal hypoglycemia, hyperbilirubinemia, hypocalcemia, and polycythemia (Meltzer et al., 1998).

Perinatal mortality is rare today in women with diagnosed GDM. However, its presence does indicate an increased risk for the mother of developing diabetes mellitus in the future. Meltzer et al. (1998) concluded that the basis for therapy is dietary adjustment, monitoring of maternal and fetal well-being, and glucose control. The use of insulin is appropriate if glucose control is not attained through diet alone.

Nutrition for a Healthy Pregnancy (Health Canada, 1999b) summarized the risk factors for GDM as follows: "Obesity; maternal age of 40 or over; family history of diabetes mellitus or GDM; ethnic groups predisposed to diabetes (e.g., Aboriginal people and people of Asian, Hispanic and African descent); large-for-date baby (over 4 kg); excessive prenatal weight gain; or previous GDM" (p. 82).

2.2.10.2. Pre-eclampsia

Pre-eclampsia is characterized by pregnancy-induced hypertension (PIH), edema, and proteinuria (Beaulieu, 1994). Osborne (1996) stated that the hypertensive component of the condition is one of the leading causes of maternal mortality and a major factor in both maternal and fetal morbidity. Pre-eclampsia occurs in about 2.6% of pregnancies (Beaulieu, 1994). "Risk factors for the development of pre-eclampsia include first pregnancy, multiple gestation, chronic hypertension or diabetes, and family history of pre-eclampsia" (Health Canada, 1999b, p. 84).

Claims that calcium supplementation during pregnancy can reduce the risk of pre-eclampsia have not been supported in the literature (Levine et al., 1997).

2.2.10.3. HIV in Pregnancy

In 1995, women represented 19% of all positive HIV test reports in Canada (Health Canada, 1997). As of June 1997, 6.9% of Canadian AIDS cases were among women, 73% of which were among women aged 15 to 44 years. The proportion of AIDS cases among adult women in Canada has increased steadily from about 6.2% before 1990 to 10.6% in 1996 (Health Canada, 1997).

Murphy (1993) suggested that pregnant women with HIV/AIDS may need dietary intervention due to a wide range of symptoms including "mouth pain, trouble swallowing, altered tastes, diarrhea, loss of appetite, nausea, vomiting, or fatigue" (Health Canada, 1999b, p. 86).

2.3. Prenatal Health Promotion Literature

After completing an extensive literature review on the issue of LBW, Alexander and Korenbrot (1995) stated that the collective evidence suggests that adequate prenatal care is associated with reduced rates of low birth weight, but mainly among full-term infants. They cautioned that prenatal care has not consistently been shown to prevent fetal growth retardation among less mature preterm infants or to prevent preterm birth (p. 2). The authors stated that "the relationship between prenatal care and very low birth weight (less than 1,500 g) and very preterm delivery (at less than 33 weeks) is also uncertain" (p. 2). Alexander and Korenbrot (1995) described the many threats to validity of inference inherent in nonrandomized studies which claim a direct relationship between some prenatal care services and mean or low birthweight. These include a failure to control for the self-selection bias of women who choose to use comprehensive care rather than standard services. Additionally, "there is very little definitive information on the extent to which individual components or combination of components of standard or comprehensive care--for example social support, home visits education, and the like--may be effective" (p. 3).

In reviewing the prenatal health promotion literature, the researcher searched for studies that considered a variety of factors relevant to the research design. These factors included (a) use of both qualitative and quantitative methodologies, (b) consideration of the broad determinants of health, (c) discussion of sustainability, empowerment, and partnerships, (d) active involvement of participants and/or community partners in program development and implementation, (e) diverse strategies focusing on the individual participant as well as on the small group, and, (f) the use of both lay and professional staff in service delivery. The individual studies reviewed in Section 2.3 incorporate some, but not all, of these factors.

Korenbrot, Showstack, Loomis and Brindis (1989) reported on 411 clients of the Teenage Pregnancy and Parenting Program (TAPP), implemented in 1981 for expectant mothers, 18 years old or younger. The primary goal of the study was to determine whether TAPP was associated with healthier birthweights. For the comparison group, data were collected from more than 2000 birth certificates from teen mothers (less than 19 years old) in San Francisco. The program used a case management approach with repetitive assessments of teens' psychosocial, health, education, nutritional, and vocational needs. Referrals were provided to appropriate agencies, including a school on the TAPP site offering two nutritious meals daily to pregnant teens. The authors concluded that TAPP clients had significantly larger babies than did the control group, after controlling for race, age, parity, and infant gender. Also, high utilization of TAPP services was highly predictive of good weight outcomes, independent of the number of medical visits. The authors suggested that the active outreach work done by TAPP minimized the self-selection bias for more motivated low-income teens.

Olds, Henderson, Tatelbaum and Chamberlin (1986) conducted a randomized controlled trial to evaluate differences in birth outcomes between standard prenatal care and more comprehensive medical, nutritional, educational, and psychosocial support services provided through a Nurse Home Visitation Program in Elmira, New York. Results were generally negative although some benefits were shown for specific populations. The comprehensive prenatal health promotion program had no overall effect on birth weight or gestational age, but improvements were noted for specific subgroups of women, for example, young adolescents and smokers.

After conducting a later study, Olds, Henderson, Klitzman, Eckenrode, Cole and Tatelbaum (1999) published updated findings on the 20-year Nurse Home Visitation Program that confirmed earlier research concluding that the program benefits the neediest families (i.e., low income unmarried women), but provided little benefit for the broader population. Long-term follow-up of families in Elmira, New York suggested that nurse-visited mothers were less likely to abuse or neglect their children or have rapid successive pregnancies. The authors hypothesized that having fewer children enabled women to work outside the home, become economically self-sufficient, and eventually avoid substance abuse and criminal behaviour. The study also documented benefits to the children born to mothers participating in the program. By the time the children were 15 years of age they had fewer arrests and convictions, smoked and drank less, and had fewer sexual partners. The authors concluded that the use of nurses as home visitors was key, and that services should be offered to the neediest populations rather than being offered on a universal basis.

McFarlane and Fehir (1994) described De Madres a Madres--a community primary health care program in Houston, Texas that began as a prenatal health promotion program and evolved into a community-wide strategy for health. "Based on the concepts of empowerment of indigenous women through unity, validation of women as key health promoters, and the acceptance of a community's ability to address and redress its own health needs," the De Madres a Madres program was started in a Houston inner-city Hispanic community in 1991 (McFarlane & Fehir, 1994, p. 381). The authors chronicled the five-year community empowerment process, based on Freire's model (1970, 1973), and documented the lessons learned. Program participants identified these aspects in the community that improved as a result of the program (McFarlane & Fehir, 1994):

> (a) Better communication among the community residents; (b) stronger coalitions formed to solve a wide range of community problems; (c) increased personal development of the program's staff and volunteers related to self-respect, self-care and a sense of belonging; (d) computer literacy and office management skills acquired by volunteers; (e) local and state political savvy and involvement; (f) craft teaching, production and marketing; and (g) grant writing, negotiating and resultant financial independence and liquidity. (p. 383)

In addition, "participants taught the evaluator about the extent of loneliness and isolation before the program began and the effect of the program on connecting people and enhancing the community economy as a whole" (p. 383).

An article by Edwards, Sim-Jones and Hotz (1994) reported on a longitudinal prospective observational study undertaken to describe the experiences of African-American women over the course of their pregnancies. The goal of the study was to investigate nutritional, medical, biomedical, psychosocial, socio-economic lifestyle, and environmental factors that influenced pregnancy outcomes in the study population. The authors reported a two-fold decrease in the incidence of low birth weight from 20.6 % to 8.3% in women enrolled in the inner-city program from 1985 to 1988. Instruments administered to the mothers were used to assess stress during pregnancy, body image, the social support network and other psychosocial factors. The significant reduction in the incidence of low birthweight in an urban African- American low-income population was attributed to the "mediation of maternal stress by project personnel" and the caring sensitive environment provided by the project clinical staff (p. 1009). The authors concluded that women with a positive self-attitude and higher self-esteem were more likely to deliver infants at term. Additionally, the number of persons in the mother's social support network was directly correlated with her infant's gestational age. The authors hypothesized that the reduction of psychological stress in low-income pregnant women will improve birth weight, when diet is nutritionally adequate. They maintained that talking to "caring others" is a form of empowerment enabling high-risk pregnant women to follow through with appropriate medical care (e.g., prescription of vitamin/mineral supplements; and regular attendance at prenatal clinic appointments).

In summary, the literature suggests that most programs directed at the prevention of low birthweight have attempted to address the individual health consequences of economic and social disadvantage. For the most part, the outcomes of these interventions on low birthweight have been inconclusive. The studies reviewed above call for a broader definition of health--one that includes social dimensions and re-focuses research and community interventions on the inter-relationships between socio-economic factors and prenatal/maternal health.

2.4. Key Canadian Prenatal Nutrition Programs

Desrosiers-Choquette and Julien (1998b) conducted a search for key Canadian prenatal programs by contacting government departments and community-based health and social agencies. The researchers also studied internal prenatal program reports. Through a four-step review and elimination process, they evaluated annual reports from eight key prenatal nutrition programs in six Canadian provinces.

Four of the eight Canadian programs reviewed by Desrosiers-Choquette and Julien (1998b) primarily focused on nutrition. The interventions with low-income, at-risk pregnant women included nutritional assessments, individualized nutrition counselling, and food supplements. The authors concluded that the four Canadian prenatal programs had "achieved very good results on birthweight outcomes" (p. 54). The brief program descriptions that follow are based on information provided by Desrosiers-Choquette and Julien (1998a, p. 54-55):

- *Halifax Milk and Orange Juice Ticket Program* (MOJT) for pregnant and breastfeeding women on social assistance. Two dietitians provide home visits to clients. Approximately 140-150 women participate in the MOJT program annually;

- *Vancouver Healthiest Babies Possible* (HBP) involves two dietitians, three lay counsellors, and interpreters. Additionally, a dietitian/co-ordinator and a clerk provide services to HBP. Prenatal and post-partum contacts take place primarily in the client's home. Approximately 440-460 women enroll in the program each year;
- *Prince Edward Prenatal Nutrition Intervention Program* (PEI) includes 5.4 dietitian positions. Dietitians provide services to high-risk cases involving both infants and preschoolers. While most of the contacts with clients take place in the home setting, staff members also encourage office appointments. On average, 400 women participate in PEI annually;
- *Montreal Diet Dispensary* (MDD) *Higgins Nutrition Intervention Program* involves 7.5 dietitian positions. Additionally, an executive director, a secretary, a receptionist and a computer-technician provide services to the MDD. The dietitians counsel most clients at the MDD, however, home visits are conducted in special circumstances. Program statistics indicate that MDD dietitians counsel approximately 2500 clients per year.

According to Desrosiers-Choquette and Julien (1998b), two additional Canadian prenatal nutrition programs have achieved impressive birthweight outcomes in recent years. At the time of the authors' review, the birthweight outcomes for the following two programs were close to those documented by the four programs mentioned above:

- *Toronto Healthiest Babies Possible* (HBP) involves a dietitian/nurse team. Four dietitians provide individualized nutritional assessments and counselling to approximately 325 participants annually. In addition to individualized services, program staff organize group activities at regularily scheduled drop-in sessions. Topics covered pertain to a wide range of health issues and/or concerns.
- *British Columbia Pregnancy Outreach Program* (POP) is "a comprehensive nutrition program" with "nutrition activities integrated into its structural components" (Desrosiers-Choquette & Julien, 1998b, p. 55). Programming includes group sessions, the provision of food as well as nutritional supplements, individual counselling, and referrals. POP operates from 21 community-based sites. A dietitian and a nurse provide services at each site, "but the amount of the time that the dietitian is available for counselling varies greatly from site to site" (p. 55). Lay

counsellors serve as the primary contact persons. Approximately 650 clients participate in POP annually.

Based on their review of prenatal nutrition programs in Canada, Desrosiers-Choquette and Julien (1998b) drew these conclusions:

1. Socially disadvantaged women and those with low self esteem respond well to individualized counselling;
2. Accurate assessment is required to identify nutritional risk of participants over and above the risks imposed by food insecurity related to low-income;
3. Canadian programs that have produced valid and consistent results are those in which dietitians/nutritionists are primary care givers, and
4. Peers and lay counsellors may be best suited to reach some women but must be trained and supervised by dietitians/nutritionists (p. 3).

Additionally, Desrosiers-Choquette and Julien (1998b) stated that while individualized nutrition counselling is associated with improved pregnancy outcomes, programming must also address the mother's need for social support. They cautioned programmers not to dilute the nutrition content of the program in favour of objectives that may be less effective in low birthweight prevention, or harder to achieve in the short intervention time available. The authors concluded by reminding readers that

> Many risk factors for poor pregnancy do not belong to low-income women alone. Thus, it is hoped that as the CPNP establishes nutrition assessment and counselling as the unequivocal basis of program delivery for the low-income population, it will give tangible support for the recognition of its importance for all pregnant women (p. 3).

2.5. Related Health Promotion/Education Literature

The increasing attention on "community" in health promotion literature reflects the growing recognition that health-related behaviours are greatly influenced by the environment in which people live and work. In recent years, researchers have developed a set of process theories that address community change. These include theories at the societal, organizational, community, and individual levels.

2.5.1 Society as the Locus of Change

The role that social, economic, environmental, and personal factors play in determining health status is of growing interest to both researchers and policy makers. This interest has resulted in the development of a population health approach--a way of meeting the challenge of achieving health for all that goes well beyond traditional programs and services in the areas of public health, medical care and health promotion. The goal of a population health approach is "to maintain and improve the health status of the entire population and to reduce inequities in health status between groups and/or subgroups" (Health Canada, 1998b, p. 1). The approach, outlined in Taking Action on Population Health, emphasized that environmental issues, social problems, economic factors, and personal habits and behaviours are all important determinants of the health and well-being of the population. Addressing the broad determinants of health is as important for population health as are good medical care, primary prevention, health promotion, and sound public policy initiatives (The NWT Health Status Report, 1999).

In a population health approach the entire range of individual and collective factors, and the ways in which they interact, are considered in planning strategies to improve health. While the approach is evolving, it is characterized by a number of elements and attributes. A population health approach

> - is a conceptual framework for thinking about health . . .;
> - includes decisions . . . that are guided by a consideration of the evidence about the relative contribution to population health status of multiple health determinants and their interactions;
> - is a framework for taking action, through policies, programs, and services, on health issues in a population that consider and respond to multiple determinants;
> - involves actions primarily targeted at the societal, community, structural, or system level which are necessary to have an impact on health status at the population or group level;
> - requires collaboration between multiple sectors . . . . Multi-sectoral analysis and decision-making characterize a population health approach. (Health Canada, 1998b, p. 2)

The population health approach moves practitioners' foci "upstream" by pointing out that it is the range of available health choices, rather than the choices made at any one time, that is critically important in shaping the overall health of a population. It recognizes that the range of choices available to individuals is largely determined by policy decisions made by government and the private sector. The "upstream approach" focuses on society as the locus of change, recognizing that

> Personal behaviour patterns are not simply 'free' choices about 'lifestyle,' isolated from their personal and economic content. Lifestyles are, rather, patterns of choices made from the alternatives that are available to people according to their socio-economic circumstances and the ease with which they are able to choose certain ones over others. (Milio, 1981, p. 76)

According to Rachlis (1999), "a particular population's health status is as unique to that society as fingerprints are to an individual" (p. 13). If we accept this premise, then, in the view of Rachlis, several important points follow:

- Major change in a society's pattern of health and illness usually requires change in that society's values and customs;
- Some powerful groups will be threatened by this change and will use their positions of privilege to oppose them. Some citizens will be offended by the new values implied by healthy public policies;
- These threats to interests and values will inevitably cause some political backlash. This backlash will alter intersectoral action and healthy public policies so that they will be less offensive to mainstream interests and values. The eventual policies implemented will usually focus on communities or individuals rather than larger populations and will almost be less effective than they would have been without the political intervention (p. 14).

Rachlis (1999) used the increase in incidence of lung cancer and consequent tobacco control activities as an illustrative parable for this framework. He presented evidence to suggest that the tobacco companies have used their privileged position to protect their interests, and have "blunted intersectoral action and healthy public policy so that they are less effective" (p. 16). The conclusions of Rachlis suggest that effective, long-term strategies to address poverty as a determinant of health in Canada will be challenged and opposed by those sectors not in favour of increasing the income of Canada's unemployed and "working poor."

2.5.2. Community-level Change Theories

At the level of the community as a whole, some theoretical approaches have been described. The most familiar is that developed by Rothman (1996, 1979). Rothman's categorization of community organization consists of three distinct models of practice:

locality development, social planning, and social action. Locality development is primarily process-oriented emphasizing the consensus and cooperation of community residents in identifying and solving a problem. The goal of locality development is to build group identity and a sense of community. The social planning approach is based on rational planning and problem solving. Planners, often external to the community, may identify particular problems and implement activities to solve the problems. The social action approach is both task- and process-oriented. Usually based in conflict, social action is concerned with achieving concrete changes to redress imbalances of power and privilege in disadvantaged groups (Minkler & Wallerstein, 1997).

Since the late 1970s, Rothman's typology (1996, 1979) has remained the dominant framework used to examine and understand the process of community organization (Minkler & Wallerstein, 1997). However, limitations of the model have surfaced over the years. For example, use of the term "locality development" may rule out community organizing along non-geographical lines (Labonte, 1994). There is also a question as to whether external researchers have the mandate to go into communities to "create" a change agenda. Freire (1970) maintained that this was a role for the community--not a role for outside technical experts. Further, the typology that Rothman (1996; 1979) developed has been criticized for being "problem-based" and "organizer-centred" (Minkler & Wallerstein, 1997, p. 246). In contrast, more recent community empowerment theories, including The Empowerment Holosphere (Labonte, 1994), are seen as "strengths-based" and "community-centred."

The newer models of collaborative empowerment and community-building practice (Figure 2.1) provide important alternatives to Rothman's typology described above. According to Minkler and Wallerstein (1997),

> These models can be seen partially as descendants of the community development model in their emphasis on self-help and collaboration. Yet they extend beyond the community development tradition that is externally driven and may implicitly accept the status quo. They take their parentage instead from community-driven development, in which community concerns direct the organizing in a process that creates healthy and more equal power relations. (p. 247)

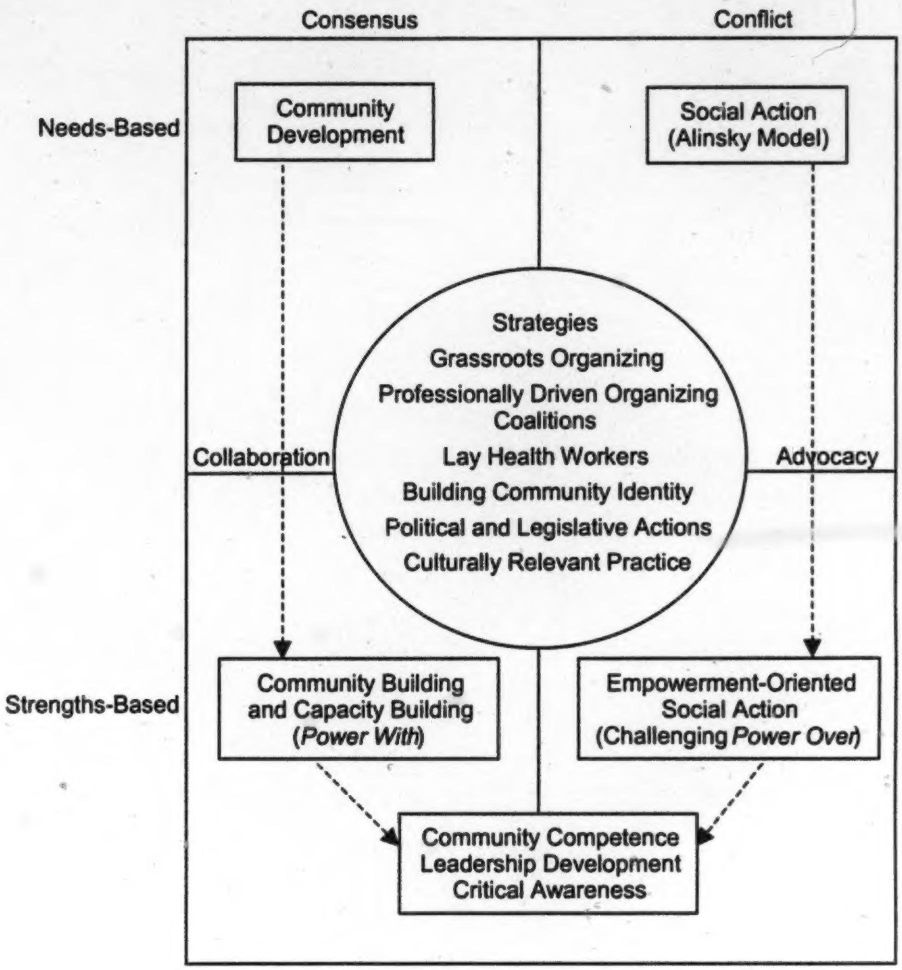

Consensus
Conflict
Needs-Based
Community Development
Social Action (Alinsky Model)
Strategies
Grassroots Organizing
Professionally Driven Organizing
Coalitions
Lay Health Workers
Building Community Identity
Political and Legislative Actions
Culturally Relevant Practice
Collaboration
Advocacy
Strengths-Based
Community Building and Capacity Building (Power With)
Empowerment-Oriented Social Action (Challenging Power Over)
Community Competence
Leadership Development
Critical Awareness

Figure 2.1. Community organization and community-building typology (Minkler & Wallerstein, 1997).

The typology presented in Figure 2.1, incorporates both needs-based and strengths-based approaches to community organizing and community-building. Along the left axis, needs-based community development approaches are depicted. Conflict-based social action approaches (Alinsky, 1972) are illustrated along the right axis. In describing the typology, Minkler and Wallerstein (1997) stated that "the newer strength-based models contrast a community-building and capacity -uilding approaches to empowerment-oriented social action" (p. 249). The two strengths-based approaches include such concepts as community competence, leadership development, and critical awareness. Although empowerment is represented in a separate "box," the authors emphasized that it is a concept that, ideally, should be represented within the other three models of community organizing. Collaboration, which is consensus-driven, is positioned as a bridging strategy on the left axis linking needs- and strengths-based approaches. Advocacy, which is conflict-driven, is positioned as a bridging strategy on the right axis.

In the middle of the model depicted in Figure 2.1, several organizing strategies are referenced including grassroots organizing and coalition-building. According to Minkler and Wallerstein (1997), these strategies are not specific to any one quadrant. Rather, "each may incorporate multiple tendencies or models depending on the starting place and the dynamics of an ever-changing social context" (p. 250).

2.5.3 Individual-level Change Theories

Theoretical approaches that focus on the individual-level of behaviour change represent a "downstream" view. By focusing on the individual, not society, as the locus of change, these theories have been described as "victim blaming (Tesh, 1988, p. 379)." The health promotion literature is permeated with individual-level theories of change. Largely derived from the field of psychology, theories that focus on individual change may be broadly categorized as follows: (a) those that focus on intrapersonal characteristics of the individual, and; (b) those that emphasize interpersonal factors as a basis for decision-making (Thompson & Kinne, 1999).

Theories that examine individual characteristics, motivation, and other unique factors that may enhance or detract from behaviour change, operate at the intrapersonal-level. One well-known theory, the health belief model (HBM) assumes that the likelihood of an action is influenced by one's perception of his/her susceptibility to the disease and the perceived severity of the disease. Together these perceptions form the individual's perception of the threat of the disease. The perceived threat can be modified by many factors such as age, gender, and knowledge, as well as by "cues to action." According to Rosenstock et al. (1988), "cues to action" include education, symptoms, and information about the disease and how to overcome it. An individual's ultimate decision about whether to take action is determined by the perceived benefits (versus perceived barriers) to changing his/her health-related behaviour (Strecher & Rosenstock, 1997; Rosenstock, Strecher, & Becker, 1988).

At the practice level, the health belief model places the burden of action totally on the client. It suggests that only those clients who have distorted or negative perceptions of the specified disease or recommended health action will fail to act. Thus, the HBM focuses the practitioner's efforts on interventions designed to modify the client's distorted perceptions. Although the health belief model was not designed to specify intervention strategies, it inadvertently can lead the practitioner to conclude that the client's problems can be solved merely by altering the client's belief system. Butterfield (1990) concluded that the HBM may be effective in promoting behavioural change through the alteration of clients' perspectives. However, a limitation of the model is that it fails to address the broader socio-environmental factors that prohibit individuals from making healthy lifestyle choices. Further, it does not acknowledge the responsibility of the healthcare professional to reduce or ameliorate client barriers to taking action.

Many other intrapersonal theories are premised on a view that behaviour is rational and determined by attitudes and beliefs. Similar to the HBM, these theories maintain that individual behaviour is based largely on internal perceptions formed as a response to beliefs of what causes disease and whether or not those causes can be overcome. A well-known theory in this domain is the theory of reasoned action (TRA) (Fishbein, 1990; Ajzen & Fishbein, 1980). This view assumes that the single best predictor of whether a person will change behaviour is "behavioural intention." According to Fishbein (1990), intention is shaped by attitudes toward the behaviour and perceptions of how others will view the behaviour. In recent years, the model has been updated to include the expanded theory of reasoned action (Montano & Taplin, 1991) and the theory of planned behaviour (Ajzen, 1991). Each of these theories adds additional factors to explain some aspect of behaviour. The commonality between the theories is their emphasis on the individual's internal processes as the primary element of change.

The other main class of individual theories of change includes the interpersonal theories. These theories serve to emphasize the importance of social relationships involving friends, families, and "significant others" in an individual's environment. Social learning theory (SLT) is perhaps the best known interpersonal theory. The SLT recognizes that simple cognitive acquaintance with new material is not sufficient to motivate individual change (Bandura, 1969). Social norms and values largely determine what advice will be considered by a client/patient, and how easily it will be accepted. Thus, the SLT constructs suggest that a change in social norms will influence people's learning and eventually their health behaviours.

Bandura's social learning approach is used extensively in the health field as a model of change. Bandura (1969), cited in Tompson and Kinne (1999), stated that according to the SLT,

> The individual is regarded as a self-determining organism who acts on and reacts to environmental stimuli and acquires new ideas and behaviours by modeling them on focal others. In practice, this type of change is promoted by exposure to these role models. This is accomplished by mass media that can increase access to the new ideas and behaviours by use of prominent people as change initiators and by exploitation of existing social networks that maximize interpersonal contact. (p. 36)

The concept of "networking"--creating social networks or linkages among individuals--is a closely related strategy to improve the chances that individuals will learn and adopt a new health-related behaviour from those in their social environments.

Although environmental factors are increasingly seen as important influences on behaviour, the SLT has been criticized for not capturing the "nonlinearities" in life. For example, sometimes individuals' lives proceed relatively smoothly, and other times, for no apparent reasons, events take a sudden and unexpected turn for the worse. Baranowski et al. (1997) described this phenomenon as "nonlinear occurrences of events and relationships over time" (p. 172). In discussing the limitations of the SLT, the authors maintained that all of the single constructs in the SLT propose linear relationships: "In theory, the more of one construct (for example, positive outcome expectancies about eating fruits and vegetables), the more likely the behaviour is to occur (for example fruit and vegetable consumption)" (p. 172). However, Baranowski et al. (1997) acknowledged that one of the constructs--the principle of reciprocal determinism--suggests the nonlinear relationships among environmental, individual, and behavioural factors. The authors concluded that more research was necessary to better understand the nonlinear aspects of the SLT.

A theoretical framework that incorporates many of the constructs associated with individual-level theories of change is the Transtheoretical Model (TTM), also referred to as the "stages of change" model. The premise of the model is that behaviour change occurs through a number of somewhat sequential stages. Prochaska, DiClemente and Norcross (1992), cited in Thompson and Kinne (1999), summarized the stages as follows:

> (a) **precontemplation**, during which an individual has no intention of changing a behaviour; (b) **contemplation**, during which individuals intend to make some changes within the next 6 months or less; (c) **preparation**, during which change is anticipated within the next 30 days; (d) **action**, during which changes are made but are not sufficient to be considered a permanent health behaviour change; (e) **maintenance**, during which behaviour change is continued over time and relapses, if any, become increasingly rare and of short duration; and (f) **termination**, during which the behaviour change is permanent and there are no tendencies to return to the old behaviour. (p. 36)

Change from one stage to the next occurs through processes or activities necessary to progress to the next stage or back to an earlier stage.

In discussing the limitations of the model, Prochaska et al. (1997) stated that additional research on the TTM was necessary to address some unanswered questions. These questions are relevant to the potential application of the model in community-based programs:

> What additional behaviors, such as stress, gambling, depression, and social isolation could be understood from a stage perspective? Can the stage model be useful in describing, explaining, and predicting change beyond the individual level, such as changes in couples, families, organizations, and communities? . . . How do diverse populations respond to stage-matched interventions . . . ? How might a program be modified to meet the needs of diverse populations? (p. 80)

The preceding review of individual-level change theories suggests that intervention strategies, targeting individuals most at risk for poor health outcomes, primarily represent interim actions intended to protect susceptible individuals, given that the underlying causes remain unknown or uncontrollable. However, Abrams et al. (1997) argued that priority should be placed on the discovery and control of the ultimate causes of modern diseases that are "rooted in economics and socio-political structures" (p. 468). Thus, the authors advocated strongly for a population-based, versus an individual approach. This suggests the need for a review of integrated models of health promotion.

2.6. An Integrated Model of Community Health Promotion

One possible solution to bridging the gap between individual and population-based approaches is to consider an integrated model of community health promotion. A model of holistic community health nursing, proposed by Laffrey and Kulbok (1999), appears in Figure 2.2.

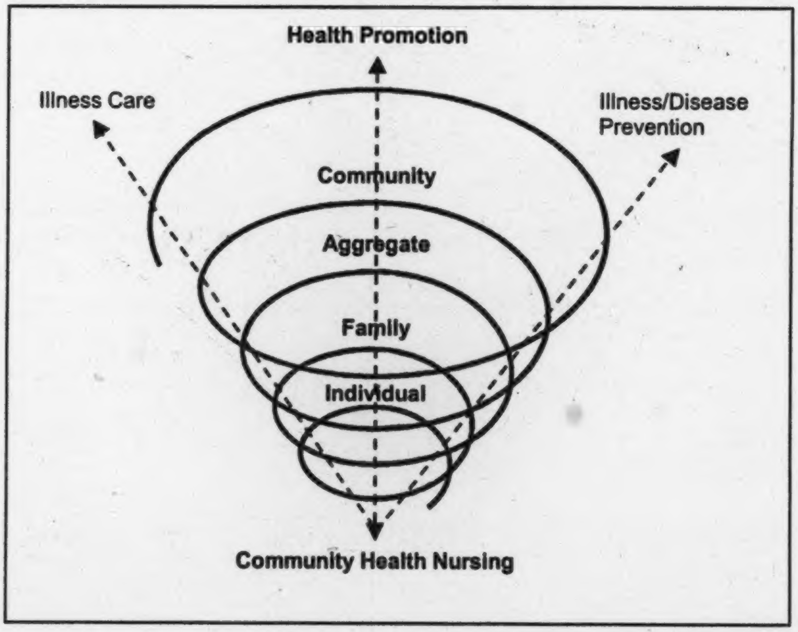

Health Promotion
Illness Care
Illness/Disease
Prevention
Community
Aggregate
Family
Individual
Community Health Nursing

Figure 2.2. Integrated model of community health promotion (Laffrey & Kulbok, 1999).

The model depicted in Figure 2.2 serves to indicate the relationship and continuity among the various levels of clients and types of care with which community health nursing is concerned. According to the model, community health nursing includes illness care; prevention of illness, disease, or injury; and health promotion. Laffrey and Craig (2000) stated that

> illness care aims to reduce illness or disability and move the client toward a state of equilibrium. Prevention of illness, disease, or injury aims to identify and reduce known health risks. Health promotion aims to increase the physical, mental, emotional, spiritual, and functional well-being of the client. These three aspects of nursing care complement one another. (p. 115)

The model suggests that the individual is the most easily defined and concrete level of client. The family, aggregate, and community "levels" become more abstract and complex. In designing the model, Laffrey and Kulbok (1999) used a spiral to indicate that care is continuous for the four client levels. The scope of community health nursing is broad and the authors emphasized that "no one nurse can attend to all levels of clients and all types of care at the same time" (p. 123). Rather, community health nurses are concerned with and have responsibilities for each level of care. Regardless of the level at which the nurse functions, the ultimate goal of community health nursing is the promotion of optimal community health. According to Laffrey and Craig (2000), "health promotion is the central axis of the model, and community is the broadest circle, encompassing the other three levels in the client's system" (p. 116).

The integrated model defines community as aggregates, families, and individuals. At a community-level, the nurse's role may be very diverse and flexible. Depending on the circumstances, the role could change from direct service provider to counselor, educator, advocate, social marketer, or community developer as the system of care increases in complexity. For example,

> At one extreme, the nurse may provide direct service to an individual client who is ill. At the other extreme, the nurse may participate with community leaders and citizens to develop health policies and resources for additional parks and recreation facilities to promote a healthier community. (p. 116)

The model reinforces the unique scope of community-based nursing practice. Community nurses provide services to individual clients within the context of their families, aggregate, and community. However, community nurses also target the community-client, appreciating its unique characteristics and needs. In summary, the model developed by Laffrey & Kulbok (1999) serves to highlight an integrated approach to community-based practice that combines both individual and population-based strategies that could apply to other health professionals.

2.7. An Empowerment Framework

A critical social perspective includes empowering strategies at these levels--interpersonal (personal empowerment), intragroup (small group development), intergroup (community organization), and interorganizational (coalition building and advocacy, political action). The Empowerment Holosphere (Labonte, 1994), illustrated in Figure 2.3, is a health promotion practice model that identifies the range of strategies that health practitioners and organizations must consider if they are to reduce or ameliorate inequitable social conditions. An individual health worker cannot assume responsibility for enacting the full range of strategies. Rather, the full range of strategies are an organizational and interorganizational mandate. According to Labonte (1994), "the individual professional's responsibility is to see that the whole process is engaged and to find a place in its engagement" (p. 258). Heuristically, the model links in practice the multiple levels of empowerment--individual, organizational, and community--described by Israel et al. (1994).

There are obvious similarities between The Empowerment Holosphere (Labonte, 1994) (Figure 2.3) and the continuum of interventions described in the ecological model for health promotion (McLeroy et al., 1988). Similar to Labonte's vision, the ecological model focuses attention on both individual and social environmental factors as targets for health promotion interventions. It addresses the importance of interventions directed at changing interpersonal, organizational, community, and public policy factors that support and maintain unhealthy behaviors. Both models--The Empowerment Holosphere (Labonte, 1994) and the ecological model for health promotion (McLeroy et al., 1988)--suggest that the "levels" of intervention should not be viewed as discrete. Rather, they are interconnected or overlapping and simply assist in the identification of the dominant emphasis of health promotion programs.

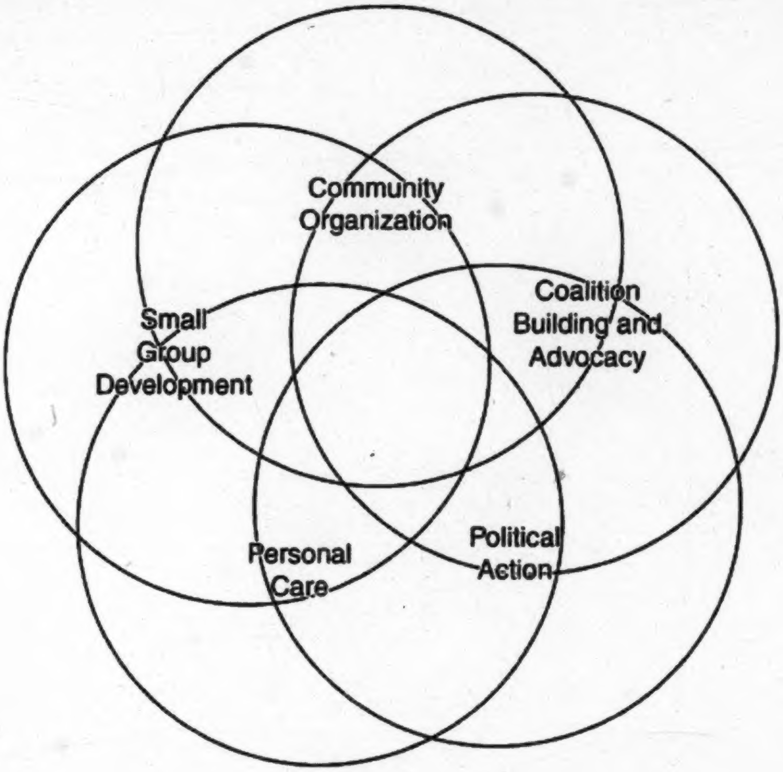

Community
Organization
Small
Group
Development
Coalition
Building and
Advocacy
Personal
Care
Political
Action

Figure 2.3. The Empowerment Holosphere (Labonte, 1994).

2.7.1 Sphere of Personal Care

McLeroy et al. (1988) stated that interventions at the intrapersonal level include educational programs, mass media, support groups, organizational incentives, and peer counseling. They emphasized that the theory of change at this "level" involves changing individuals. Thus, the targets of the intervention include characteristics of the individual such as knowledge, attitudes, skills, or interventions to comply with behavioral norms. McLeroy et al. cautioned that "these interventions may reflect the implicit assumption that the proximal causes of behavior and/or mechanisms for producing behavior change lie within the individual, rather than in the social environment" (p. 356).

The sphere of The Empowerment Holospehere (Labonte, 1994) entitled Personal Care (Figure 2.3) roughly corresponds to the intrapersonal factors identified by McLeroy et al. (1988). This sphere focuses on the characteristics of the individual such as knowledge, attitudes, and skills that are primarily responsible for health behaviors. Although individual knowledge and attitudes may be necessary for behavior change, they should remain secondary to environmental approaches including changes in the physical and social environment (McLeroy, 1988). Interventions at the level of Personal Care fail to recognize the complexities of human behavior and thereby ignore the crucial connection between individual behavior and social norms and rewards. They represent "a victim-blaming approach" to disease (Tesh, 1988, p. 379).

Despite the limitations of empowering interventions directed at Personal Care, health promotion practitioners have a role in providing services at the individual level that minimize the effects of poverty. Empowering services should be offered that respect individual autonomy, are culturally sensitive, understand the psychosocial and socio-environmental context of the individual's concerns and problems, and increase the capacity of individuals to act upon the symptoms and roots of their distress (Labonte, 1993). According to Reutter (2000), an empowering approach means

> listening to the impoverished to understand their experiences, acknowledging not only their constraints but also their strengths, exploring realistic suggestions and alternatives, and advocating for and with clients to access resources. Home visiting affords excellent opportunities for personal empowerment. (p. 185)

2.7.2 Sphere of Small Group Development

Labonte (1994) suggested that health promotion literature often presents the "community" as "the engine of health promotion" (p. 62). However, a more accurate definition would clarify that that the small group is in fact, "that locus of change--that vehicle of emancipation" (p. 62). Wallerstein (1992) also emphasized the significance of the small group stating that through the process of interacting with others, individuals develop "healthful characteristics" associated with empowerment. These characteristics included: control, capacity, coherence, and connectedness.

McLeroy et al. (1988) maintained that interpersonal relationships with family members, friends, neighbours, and acquaintances, were important sources of influence in the health-related behavior of individuals. The ecological model of health promotion is based on the premise that social relationships are essential aspects of social identity. According to McLeroy et al.,

> They [social relationships] provide important social resources, including emotional support, information, access to new social contacts and social roles, and tangible aid and assistance in fulfilling social and personal obligations and responsibilities. These social resources, frequently referred to as social support, are important mediators of life stress, and important components of overall well-being. (p. 357)

The authors also suggested that traditional health promotion interventions typically focused on changing individuals through social influences (e.g., peer outreach) rather than changing the norms or social groups to which individuals belong. In this regard, the views of McLeroy et al. concur with those of Labonte (1994).

Small group development is a time-consuming process. In the view of Labonte (1994), "it often takes between one and two years before the first 'group' squiggle may form from the disconnected individual dots, group formation occurring when individuals self identify as group members" (p. 63). Unfortunately, the timelines associated with small group development are not well understood by program funders. It is not uncommon for funding agencies to demand social action, healthy public policy, and other concrete program outcomes within the first year of program operations. Labonte (1994) cautioned that it is highly unrealistic for program funders to expect newly formed groups to deal with issues external to their own group dynamics, such as coalition building and advocacy.

Strategies focusing on small group development run the risk of dealing only with individuals and individual issues and/or concerns. One outcome is that the root causes of powerlessness are ignored. According to Labonte (1994), many self-help groups and organizations "deliberately avoid socio-political actions, drawing a boundary between the community of direct members and their needs, and the larger social communities with which they interact" (p. 64). Further, traditional health promotion practices focused on enhancing self-esteem, social support, and self-help through small group development, may mask political motivations to reduce social service or health service expenditures.

2.7.3. Sphere of Community Organization

A first step in considering the construct of community organization is to acknowledge that there are many notions of community. From a sociological perspective, the concept of community refers to a group of people united by at least one common characteristic. According to the CDC/ATSDR Committee on Community Engagement (2000), these characteristics could include geography, shared interests, values, experiences, or traditions.

A second notion refers to communities as systems composed of individual members and sectors that have a variety of distinct characteristics and interrelationships (Thompson et al., 1990). These sectors include groups of individuals having specialized functions, activities, or interests within a community system. Each sector is bound by specific rules and regulations, both formal and informal, to meet the needs of its members and the intended recipients of services. The systems perspective envisions a community as a

> living organism, or well-oiled machine. For the community to be successful, each sector has its role and failure to perform that role in relationship to the whole organism or machine will diminish success. In a systems view, healthy communities are those that have well-integrated, interdependent sectors that share responsibility to resolve problems and enhance the well-being of the community. (CDC/ATSDR Committee on Community Engagement, 1, 2000)

Community organizing can be an empowering process for individuals, communities, and organizations. At the individual level, involvement in community organization leads to an increased sense of control, improved self-confidence, and enhanced coping capacities (Minkler, 1997). This, in turn, results in physical health benefits (CDC/ATSDR Committee on Community Engagement, 2000).

At the community level, organizing activities increase the capacities of communities to respond effectively to common issues and concerns. According to Rich et al. (1995), both individuals and organizations can be empowered by "having information about problems and an open process of accumulating and evaluating evidence and information" (p. 669).

The ecological model for health promotion includes Organizational (institutional) Factors in the discussion of social and environmental determinants of health (McLeroy, 1988). According to McLeroy (1988), "organizations are important sources and transmitters of social norms and values, particularly through individual work groups and socialization into organizational cultures" (p. 360). Hence, community-based organizations serve as important mediators or mediating structures between individuals and the larger socio-economic environment. McLeroy et al. (1988) argued that organizations have a critical role to play in program diffusion. Few community health programs are "free standing." In fact, most health promotion programs are housed within some type of "host" organization or community agency. Thus, an important organizational focus for health promotion programs is securing upper level management support for activities within the host and/or partner organizations. McLeroy (1988) pointed out that various organizational processes operate at each stage of program development and implementation. The extent to which host and/or partner organizations support the program largely determines its ongoing success and institutionalization within the community.

2.7.4. Coalition Building and Advocacy

Labonte (1994) maintained that coalition building and advocacy overcome some of the inherent limitations of community organizing in the process of social change. The two constructs--coalition building and advocacy--are linked in The Empowerment Holosphere (Labonte, 1994) because "advocacy usually involves coalitions" (p. 76).

A community coalition can be defined as "a formal alliance of organizations, groups, and agencies that have come together to work for a common goal" (Florin et al., 1993, p. 417). Coalitions are often conceptualized as "formal, multi-purpose, and long-term alliances" that "fulfill planning, coordinating, and advocacy functions for their communities" (Butterfoss et al., 1993, p. 318). The positive outcomes of coalitions include "maximizing the influence of individuals and organizations, exploiting new resources, and reducing duplication of effort (CDC/ATSDR Committee on Community Engagement, 2000). A review of the literature suggests that health coalitions have not been studied systematically. According to Butterfoss et al. (1993), there is a paucity of documentation to support the effectiveness of community-based coalitions. This is surprising given the emphasis that funding sources place on developing coalitions as an intervention to address complex health and social issues.

The CDC/ATSDR Committee on Community Engagement (2000) suggested that a critical set of organizing concepts underpin coalitions. These concepts are partially based on coalition partners' assessments of the benefits and costs of community engagement. More specifically, "participants will invest their energy in an organization only if the expected benefits outweigh the costs that are entailed" (Butterfoss et al., 1993, p. 322). Potential benefits include networking opportunities, access to information and resources, personal recognition, skill enhancement, and; a sense of contribution and helpfulness in solving community problems. Potential costs include the time and energy required and the lack of skills and/or resources needed for participation. The CDC/ATSDR Committee on Community Engagement suggests that "by identifying the specific benefits and barriers to participate in the engagement effort, community leaders can put the appropriate incentives in place" (CDC/ATSDR Committee on Community Engagement. (December 1, 2000). Community engagement: Definitions and organizing concepts from the literature. In Principles of Community Engagement [On-line]. Available: http://www.cdc.gov/phppo/pce/part1.htm).

Gray (1989), cited in Labonte (1993), designed a comprehensive collaboration model. She described successful inter-group collaboration as "a mutual search for information and solutions" (p. 80). Gray delineated five features of the model which characterize "the process as outcome":

> (1) enhanced recognition of stakeholder interdependence; (2) differences are dealt with constructively; (3) joint ownership of decisions is developed; (4) stakeholders assume collective responsibility for 'managing the problem domain' through formal and informal agreements; (5) the process is accepted as continually emergent. (p. 80)

In discussing the collaboration model, Gray (1989) identified the importance of the initial step--problem setting. This step required "a common definition of the problem," a "commitment to collaborate," and "identification of the stakeholders" (p. 80). She described the goal of the pre-negotiation stage as arriving at a common definition of the problem, and a shared sense of purpose, in order to get the necessary stakeholders to the table. According to Gray, effective collaborating requires the skills and energies of persons that she labeled "midwives"--the community developers of organizations-as-communities" (p. 80). These "midwives," at arms-length functionally from all of the stakeholders, work with the stakeholders in the pre-negotiation stage of coalition-building.

2.7.5. Political Action

Labonte (1994) argued that political action represents an intensification of actions initiated at the "level" of coalition advocacy. He stated that

> the line between what comprises coalition advocacy and what constitutes political action is fuzzy; one important difference may lie in the role played by organizations and groups loosely considered to be representatives of social movements. A coalition or alliances of groups coalesces actions around a particular issue that cuts across differing commonwealths of values; a social movement brings its commonwealth of values to social issues (p. 78).

Labonte used the growing "Healthy Cities" movement as an example of an authentic partnership with a proven track-record in accomplishing social change through political action. He attributed the "Healthy Cities" coalition's success to

> their relative endurance; a degree of autonomy from normal government-decision-making processes; a deliberate 'search for meaning' involving value-based goal definitions, and participation by a broader range of stakeholders including groups or sectors representing the more formally organized elements of social movements. (p. 79)

The ecological model for health promotion (McLeroy et al., 1988) also addresses the significance of political action in achieving social change. The authors emphasized that there are several important roles for health promotion practitioners in policy development, policy advocacy, and policy analysis. Specific examples of policy advocacy include encouraging citizen participation in the political process--"voting and lobbying, organizing coalitions to support health policy related issues; and monitoring implementation at the federal, state, and local level" (p. 366).

2.8. The Role of Empowerment as a Health-enhancing Strategy

Powerlessness, or lack of control over destiny, emerges as a broad-based risk factor for disease (Wallerstein, 1992). Empowerment, although difficult to measure, can be demonstrated as an important promoter of health. As broadly defined by Wallerstein, 1992, empowerment is a

> multi-level construct that involves people assuming control and mastery over their lives in the context of their social and political environment; they gain a sense of control and purposefulness to exert political power as they participate in the democratic life of their community for social change. (p. 198)

Wallerstein (1992) maintained that an ecological construct applies to interactive change on multiple levels--the individual, organization, and community. Thus, she suggested that a study of empowerment implied not just studying individual change but also change in the social setting itself. This is consistent with the views of Labonte (1994) and McLeroy (1988) described above. After reviewing the literature in the fields of social epidemiology, stress research, social psychology, social support, and community psychology, Wallerstein (1992) concluded that control over destiny, or lack thereof, is a disease risk factor. She proposed that "being poor, low in the hierarchy, without control, and living in chronic hardship--in other words experiencing powerlessness--is itself a broad risk factor that increases susceptibility to higher morbidity and mortality rates" (p. 199).

In Figure 2.4, Wallerstein (1992) synthesized the variables that contribute to powerlessness and empowerment. The top diagram is entitled "Powerlessness" and the bottom diagram is entitled "Empowerment." According to the author, the physical and social risk factors for powerlessness include poverty, low social status, high demand (psychological and physical), low control, chronic stress, and a lack of social support and resources. Figure 2.4 (top diagram) also indicates that an external locus of control is a risk factor for powerlessness. Locus of control is a generalized belief about one's ability to control events by virtue of one's own efforts (Rotter, 1966). At an individual level, people with an internal locus of control are more likely to initiate health-enhancing behaviors on their own, demonstrating better compliance rates and fewer illnesses than people with an external locus of control. Interventions which attempt to increase internal locus of control, without changing the environmental conditions, may increase frustration and lead to greater perceived powerlessness and ill-health (Wallerstein, 1992).

Wallerstein (1992) included a lack of social support as a risk factor for powerlessness (Figure 2.4: Powerlessness and Empowerment). Although conceptualizations and forms of measurement may vary, substantial evidence exists that social support has beneficial effects on psychological and physical well-being (Israel &

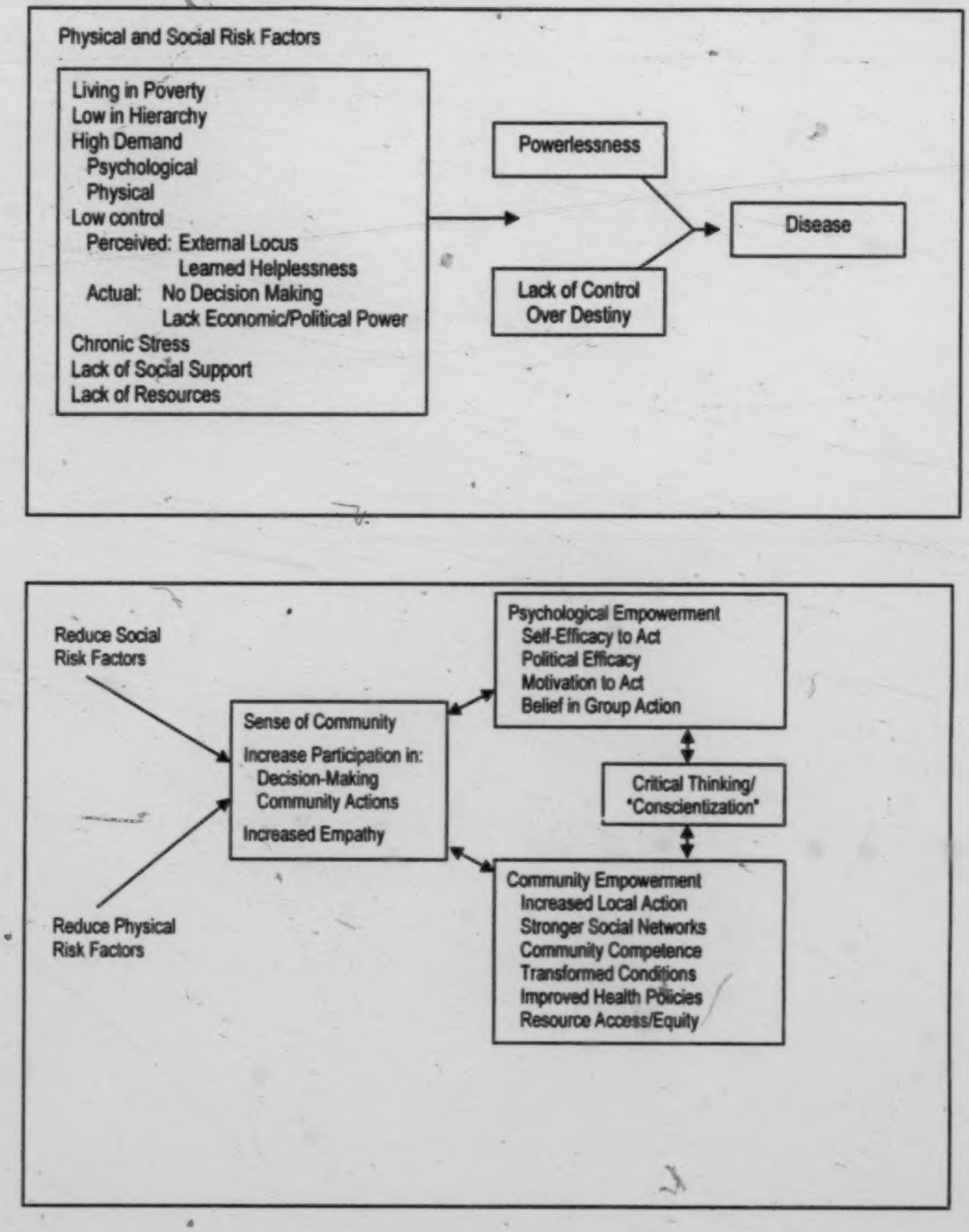

Physical and Social Risk Factors
Living in Poverty
Low in Hierarchy
High Demand
Psychological
Physical
Low control
Perceived: External Locus
Learned Helplessness
Actual: No Decision Making
Lack Economic/Political Power
Chronic Stress
Lack of Social Support
Lack of Resources
Powerlessness
Lack of Control Over Destiny
Disease
Reduce Social Risk Factors
Reduce Physical Risk Factors
Sense of Community
Increase Participation in:
Decision-Making
Community Actions
Increased Empathy
Psychological Empowerment
Self-Efficacy to Act
Political Efficacy
Motivation to Act
Belief in Group Action
Critical Thinking/ "Conscientization"
Community Empowerment
Increased Local Action
Stronger Social Networks
Community Competence
Transformed Conditions
Improved Health Policies
Resource Access/Equity

Figure 2.4: Powerlessness and Empowerment (Wallerstein, 1992).

Schurman, 1990). The literature on social support translates social support into a community framework, examining the health outcomes that result from strengthening community networks. According to Wallerstein (1992), social support networks at the community level have taken two forms: "promoting lay helpers and developing community-level, problem-solving mechanisms that empower the community and secondarily enhance social networks" (p. 200). Support, particularly from peers, can empower people (Labonte, 1993) and enhance self-efficacy and self-esteem (Katz, 1993; Stewart, 1990b; 2000).

2.9. An Empowerment Education Approach

An empowerment education approach engages people through group discussion in identifying their own problems and in critically assessing the social, historical, and cultural roots of their problems. Collectively the group develops action strategies to change the personal and social lives of its members. Rather than seeing empowerment education as seeking power over others, it is a strategy to develop power with others to effect change. According to Labonte (1994), "power-with" approaches value the reality of lived experience "in the language, images and symbols that people use to give voice to them" (p. 54).

Many of the theoretical constructs underpinning empowerment education come from Paulo Freire's highly successful literacy programs for slum dwellers in Brazil. According to Freire, the social context of education is not neutral. People born and raised in situations of powerlessness often perceive a lack of control over their destinies. The powerlessness and learned helplessness experienced by the disadvantaged colors their interactions with health professionals. Traditional approaches to education, in which people are treated as objects to be manipulated, reinforce feelings of powerlessness. Freire (1971) described traditional education as "banking": "The teacher's job is to 'fill' the students by making deposits of information which the teacher considers to constitute true knowledge. The student's job is merely to 'store' the deposits " (p. 63).

In contrast, empowerment education encourages people to question and challenge those forces that keep them powerless. According to Freire (1971), the purpose of education should be human liberation, where "people are subjects of their own learning not empty vessels filled by teachers' knowledge" (p. 203). Freire employed a listening-dialogue approach to learning that reflected a participatory social orientation. He maintained that the initial step involved listening to people's life experiences and making participants co-investigators of their shared problems.

In discussing an empowerment approach to education, the feminist literature introduced the concept of "midwife-teachers," the opposite of "banker-teachers" as described by Freire (Belenky et al., 1986). While banker-teachers deposit knowledge in the students' heads, midwife-teachers draw it out. According to Belenky et al. (1986), "they [midwife-teachers] assist the students in giving birth to their own ideas, in making their own tacit knowledge explicit and elaborating it "(p. 217). Midwife-teachers facilitate the process of critical thinking by encouraging students to speak in their own active voices. Wallerstein (1992) cautioned that the listening-dialogue approach advocated by Freire should not be confused with a "needs assessment." Rather, it is a participatory and ongoing process which reveals issues of emotional and social significance to those involved.

The second step in empowerment education is engaging in "dialogue" about those issues uncovered during the listening phase. In this stage of the process, midwife-teachers focus not on their knowledge (as the traditional teacher does) but on the students' knowledge. "Midwife teachers help students deliver their words to the world--to use their knowledge in everyday life" (Belenky et al., 1986, p. 219). The purpose of Freirian group dialogue is problem-posing to analyze the root causes of one's situation in society--the socioeconomic, political, cultural, and historical context of personal lives. The goal of critical thinking is to move beyond perceptions towards personal and social action. In the words of Wallerstein (1992),

> When people develop action plans for their own communities they simultaneously develop a belief that they can make a difference in their own lives and in the lives of those around them. Empowerment therefore evolves from the interaction of reflection and action, or praxis, that can transform social conditions. (p. 204)

The process of conscientization, or critical thinking based on action, links personal, and community empowerment (Figure 2.4, Powerlessness and Empowerment). Critical thinking about the social and environmental context of people's lives connects individuals as members of a common community and facilitates efforts to transform inequitable social relations.

Wallerstein and Sanchez-Merki (1994) used qualitative research data to illustrate how Paulo Freire's social change theory could be combined with a cognitive and behaviour change theory to develop a comprehensive health education program focusing on both individual and community-level change. While the discussion centred on the Alcohol and Substance Abuse Prevention (ASAP) Program, targeting youth from high-risk communities in New Mexico, the research raised important issues for health education, including prenatal health promotion practice. Wallerstein and Sanchez-Merki (1994) emphasized that the role of the health educator as a co-learner, is important. The authors described the power dynamics that permeate most relationships between community members and health educators, whether because of expertise, or because professionals often come from a different social class or ethnic group than their target population.

Wallerstein and Sanchez-Merki (1994) stated that the goal of Freiran action is to "promote community development and to change power relationships, ultimately giving people a greater voice in community decision making" (p. 117). The researchers suggested that a Freirian approach enables both sides--health educator and community member--to analyze social problems and learn how to challenge the hierarchies together. Wallerstein and Sanchez-Merki (1994) indicated that it takes time and trust for the group to evolve into a genuine co-learner model, based on equal participation. They argued that self-reflection on the part of the health educator is necessary to understand his/her role in community change and how actions taken with the group may either challenge the status quo or promote further dependency. In an earlier article on empowerment education, Wallerstein and Bernstein (1988) concluded that "by becoming incorporated into current prevention approaches, empowerment education can enhance changes in personal growth, social support, community organizing, policy and environmental changes, and other indicators of control over one life's in society" (p. 390).

The Action Statement for Health Promotion in Canada (Canadian Public Health Association, 1996) included recommendations pertaining to strengthening community's priorities for action. The Statement recognized the power dynamics at play within health organizations, and strongly concurred with Wallerstein and Sanchez-Merki (1994) that power be shared more widely. However, the authors reminded us that many health care and community workers feel powerless in their own organizations, and that "before they can share power, they must first have power to share" (p. 5).

2.10. The Concept of "Cultural Brokerage"

Community-based health agencies and organizations are increasingly "multiculturalizing" their services and restructuring programs to meet the needs of a culturally diverse population. Stevens (1993) identified five approaches that community health agencies used to serve culturally diverse clients: parallel services, ethno-specific services, generic services, bridging services, and adapted or "multiculturalized" mainstream services. Rather than relying on one approach, most agencies have used a combination of approaches on a regular basis. Agencies that employed "multiculturalized" services recognized the need for special programs for culturally diverse clients and developed such programs, often by employing staff to assist employees in the multiculturalizing process. Bridging approaches have involved the use of interpreter services, contracted by a health agency, to facilitate communication with culturally diverse groups.

According to DeSantis (1994), the following three cultural influences operate in each interaction between a health professional and a patient/client:

> The beliefs, values, and worldview of the health professional; the beliefs, values and worldview of the patient; and the context in which the provider-patient interaction takes place (e.g., hospital, clinic, or community setting). From a transactional perspective, health professionals respond to patients on the basis of their own perceptions of clinical reality and their expectations of patients, while at the same time, patients respond to professionals on the basis of their beliefs and their expectations of health professionals. Furthermore, their interactions are influenced by cultural norms (e.g., active patient participation or passive compliance) that operate within the various health care settings. (p. 300)

Individual cultural beliefs strongly influence the interactions that occur between providers and patients/clients in health care settings. DeSantis (1994) coined the term "dual ethnocentrism" to describe the different cultural orientations that may exist. He suggested that health professionals should acknowledge their own values and beliefs in order to determine where there is potential for cultural conflicts occurring with clients. Further, DeSantis emphasized that each individual "brings his or her unique perspective to the encounter and that no one operates from a blank slate" (p. 300).

Given the "gap" in perspectives that is likely to exist in health encounters, professionals need to develop skills that will enable them to understand and negotiate differing worldviews. Several authors have referred to this skill as "cultural brokering", defined by Jezewski (1995) as the "act of bridging, linking, or mediating between groups or persons of different cultural systems for the purpose of reducing conflict or producing change" (p. 20). Cultural brokering theory outlines strategies, or stages, that health professionals could consider when working with clients from other cultural groups. Kulig (2000) reviewed these stages in her research on cross-cultural nursing:

> The first stage is to perceive the need for brokering by identifying the issue. The second stage focuses on the intervention, which includes establishing rapport and addressing the issue through actions as negotiating, advocating, or mediating. The third stage, or outcome, includes assessing the situation for resolution. The process is repeated until a satisfactory outcome results. (p. 206)

2.11. Interdisciplinary Collaboration

The Action Statement for Health Promotion in Canada (Canadian Public Health Association, 1996) identified three priority areas for action: (1) advocating healthy public policy, (2) strengthening communities, and (3) reforming health systems. Reform of health systems called for improved interdisciplinary health promotion practice and stronger alliances among those who are working in health promotion, population health, community social services, and primary health care. The Action Statement emphasized the need to document case studies of interdisciplinary health programs that have successfully integrated efforts in primary health care and health promotion. Additionally, the authors suggested that stronger professional alliances would come from sharing different perspectives on how to promote health, encouraging interdisciplinary action on the determinants of health, and strengthening the collective voice for advocating healthy public policies. (p. 7)

While interdisciplinary collaboration may be a key approach in dealing with today's complex health issues, there continues to be a lack of understanding of the factors that promote or hinder its functioning. Interdisciplinary teamwork requires common objectives, clear understanding of members' roles, mutual respect for each others' roles and skills, a flexible approach (Poulton & West, 1993), and shared leadership (Pearson, 1992). Additionally, Ritchie (1994) stated that advocacy, mediation, and negotiation skills were essential in interdisciplinary collaboration.

Laschinger and Weston (1995) stated that while some progress has been made in understanding one another's role there is much confusion about the unique expertise of each professional. This lack of understanding has been cited as a leading cause of role ambiguity and "turf" disputes among the various health disciplines. According to the authors, the greater the gap in professionals' understandings of one another's roles, the more negative they will be toward collaborative decision making.

Stewart (1990a) argued that primary health care rests on more than professional collaboration. She emphasized the importance of partnerships with focal persons (i.e., clients or patients), social networks, and lay helpers or peer staff. Laypersons and health professionals have identified role ambiguity as a barrier to relationships (Northouse & Northhouse, 1998). Stewart (1990a) stated that role conflict and/or confusion between lay and professional helpers must be prevented by the re-socialization of roles. She explained:

> Experiential knowledge and expertise of lay help movements may be in conflict with professional knowledge and competence acquired by nurses and hence must be respected and accorded equal status if nurse-social network collaboration and partnerships are to occur. (p. 16)

As health professionals' roles at the community level have expanded in recent years, professional boundaries have become blurred. Lister (1980) noted that role overlap occurred especially in those areas that were outside the more traditional role of a particular discipline. When health professionals' roles overlap considerably, one professional may think that another member of the team is trying to undermine her role or take over her responsibilities. This often results in unproductive interdisciplinary competition.

2.12. Social Support

Social support is a significant concept for health promotion practitioners because it influences health status, health behavior, and health services use (Stewart, 2000). Social support is defined as interactions with family members, friends, peer staff, and health care providers that communicate information, esteem, aid, and emotional help. According to Stewart (1990b), "these communications may improve coping, moderate the impact of stressors, and promote health and self-care" (p. 7). Social support, as a coping resource or coping assistance (Thoits, 1995) modifies the impact of acute and chronic stressors on health outcomes. Stewart (2000) stated that support and coping have a reciprocal relationship:

> Supportive persons can alter appraisal of stressors, sustain coping efforts, and influence choice of coping strategies. Conversely, the ways in which an individual copes provides important clues to potential supporters about whether support is needed and, if it is, about the types of support required. (p. 91)

Current health promotion research focuses on three hypotheses explaining the relationship of social support to health. Tilden and Weinert (1987) summarized them as follows: social support may play a preventive role in stress reduction; social support may "buffer or cushion" stress; and social support may have a positive and direct effect on health that is completely unrelated to stress. According to Stewart (2000), "the 'buffering model' suggests that social support protects individuals from harmful influences of stressful situations and enhances coping abilities" (p. 93).

In an earlier article, Stewart (1990a) developed a framework for nursing education, shown in Figure 2.5, that reflects the indirect (buffering) effects of environmental social support on physical and mental health. According to the framework, interaction is a linking concept between three systems: it appears as focal person-environment interaction; as nurse-environment interaction; and as nurse-focal person interaction. Stewart's (1990a) conceptualization of nursing practice based on social support requires a shift in roles emphasizing primary health care, consultant, and partner. The framework proposes collaborative modes of professional-social network interaction, as opposed to "coexisting, conflicting or co-opting modes" (p. 13). The author's use of the term "focal person" is significant. It reflects a principle of primary health care that

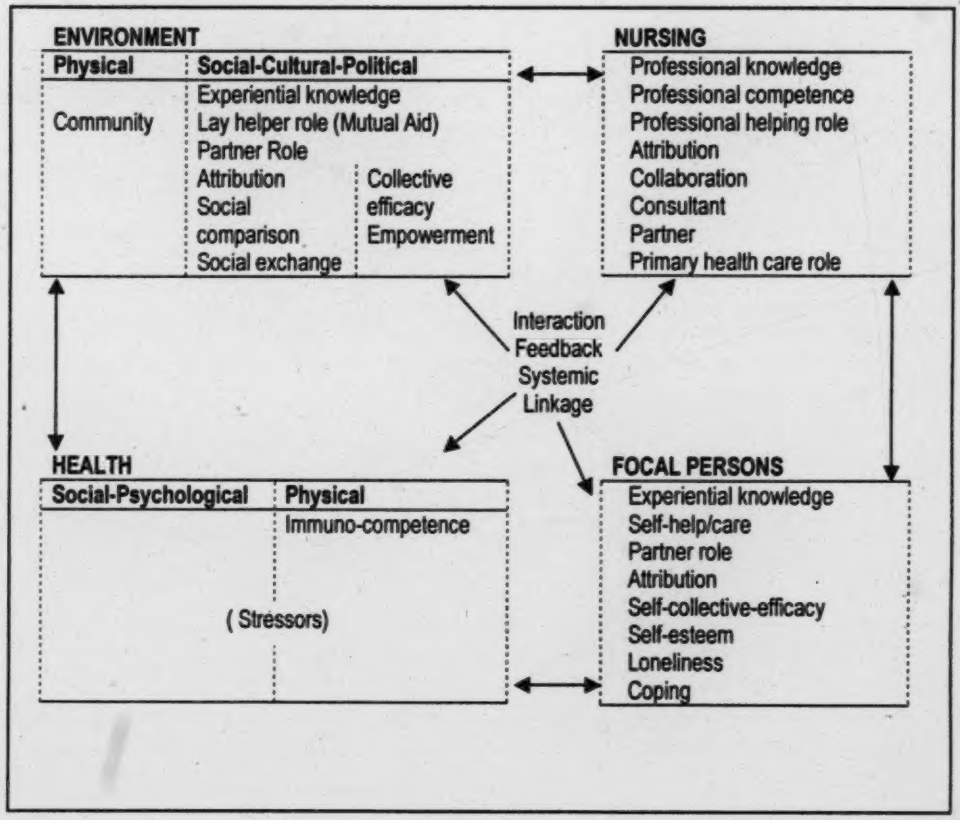

ENVIRONMENT
Physical
Social-Cultural-Political
Experiential knowledge
Community
Lay helper role (Mutual Aid)
Partner Role
Attribution
Social comparison
Social exchange
Collective efficacy
Empowerment
NURSING
Professional knowledge
Professional competence
Professional helping role
Attribution
Collaboration
Consultant
Partner
Primary health care role
Interaction
Feedback
Systemic
Linkage
HEALTH
Social-Psychological
Physical
Immuno-competence
(Stressors)
FOCAL PERSONS
Experiential knowledge
Self-help/care
Partner role
Attribution
Self-collective-efficacy
Self-esteem
Loneliness
Coping

Figure 2.5: Nursing education model based on social support (Stewart, 1990a).

elevates the passive, subservient role of patient and/or client to an active role of participant or equal partner. In designing the conceptual model, Stewart (1990a) envisioned health promotion programs based on professional collaboration and partnership with focal persons, social networks and lay helpers.

Stewart (1990a) stated that the successful implementation of the framework was contingent on educating nurses, and other health professionals, in new ways of working with lay staff. She identified many outstanding issues for nurses that needed to be addressed in their professional training:

> Increased tensions in relationships with laypersons, deficit professional knowledge and skill base, requisite role redefinition, neglected support interventions in nursing research, poorly conceptualized environmental domain in nursing theories, pressures for paradigm shifts away from the medical model, and concomitant preoccupation with illness, cure, and institutionalization care. (p. 19)

Stewart (1990a) concluded that the transition from the role of expert to one of equal partner required basic modification of practitioners' roles. She called for the "re-socialization or re-professionalization" of nursing roles at the community level to assist service providers in collaborating with informal social support networks (p. 10).

A recent Canadian study investigated the causes of smoking, and cessation, among disadvantaged women in Atlantic Canada. The research emphasized the significance of social support in behaviour change. The factors associated with smoking included "coping with stresses, loneliness, powerlessness, low self-efficacy, social pressures, and addictions" (Stewart, Gillis, Brosky, Johnston, Kirkland et al., 1996, p. 42). Importantly, findings suggested that support from health professionals and traditional cessation programs were not perceived as helpful. However, support from peers--women in similar circumstances--and partners were considered critically important. The role of peer support groups in facilitating smoking cessation was a central theme in responses by almost all of the 126 participants. They expressed interest in mutual-aid groups in which peers would assume the leadership and determine the program content. The researchers concluded that for disadvantaged women, "smoking was found to be inextricably linked with the social context and stresses in their lives" (p. 56). The study's conclusions have broad implications for health education practice, including prenatal health promotion programs. According to the authors,

> Comprehensive smoking cessation programs targeting disadvantaged women should focus on their social, economic, and cultural environment rather than on their health behaviour alone, and should be accessible in terms of cost, culture, location, literacy, and childcare. Interventions should mobilize the support of family and friends, encompass support from peers and health professionals, and foster efficacy, empowerment and esteem of participants. (p. 56)

Finally, Stewart et al. (1996) concluded that "disadvantaged women should be offered the opportunity to participate as partners in the design and evaluation of smoking cessation programs that address their priority concerns and in policy changes pertaining to social and health programs" (p. 56).

2.13. Community Development

Researchers have described the importance of health educators permitting individuals and communities to articulate their health needs. Labonte (1993) stated that allowing individual and groups to identify their own health issues and concerns is one of the most important axioms of an empowering health promotion practice. He maintained that most health agencies work from a community-based, rather than a community development perspective, and in doing so "make invisible the power differences that characterize community group/institutional relations" (p. 36). Labonte argued that a community development approach to program planning is different from a community-based approach in these three fundamental ways:

1. It is a deliberately repetitive process based on ongoing negotiations between organizations and community groups, via the community development worker;
2. Goals and objectives emerge through the process and are subject to constant revision – these emergent learnings are not "unintended outcomes"; they are the plan;
3. Quantitative measures are utilized when appropriate, but much of the evaluation relies upon qualitative measures (p. 36).

Labonte concluded that one of the characteristics of the community development approach is that power relations are constantly negotiated and shared. The health professional makes an authentic commitment to "hearing the experience of people's lives, to understanding these experiences in the words people use to express them, and to negotiating mutual actions to improve the situations that people would like to alter" (p. 41).

McKnight (1997) differentiated between traditional needs-based community programming and a community development approach with a capacity-oriented emphasis. He maintained that lower income urban neighbourhoods were often noted for their deficiencies and needs. Politicians then attempted to design solutions through "deficiency-oriented" policies and programs. McKnight described many low-income urban neighbourhoods as "environments of service" where residents saw themselves as people with special needs to be met by outsiders (e.g., health and social service workers). McKnight suggested an alternative approach to developing policies and activities based on the capacities, skills, and assets of low-income people and their neighbourhoods. He argued that significant community development can only take place when local community people are committed to investing themselves and their resources in the effort. In McKnight's words: "You can't develop communities from the top down, or from the outside in" (p. 158). Rather, outsiders can provide valuable assistance to communities that are actively developing their own assets. According to McKnight, the process of identifying capacities and assets, both individually and organizational, is the first step towards community regeneration (p. 159).

While community participation has been recognized as a central tenet in community health education practice, Minkler and Pies (1997) suggested that it is important to determine whether the participation is "real" or "symbolic." They pointed out that acting on the principle of high-level community involvement has proved very challenging. In an earlier attempt to define community participation, Arnstein (1969) developed a "ladder of participation." She described the bottom rungs of the ladder as therapy and manipulation--two forms of "non-participation." The middle rungs of the ladder were described as "degrees of tokenism" and included placation, consultation, and informing. Arnstein stated that these were processes through which community members were heard, but their advice was not necessarily heeded. The top rungs of Arnstein's ladder were described as three degrees of citizen power--partnership, delegated power, and true citizen power.

According to Robertson and Minkler (1994), much current health education practice uses the rhetoric of high-level community participation, but in reality it is operating at the lower rungs of the ladder. This addresses health professionals' attempts to get people in the community to take ownership of a professionally defined health agenda. Labonte (1994) refered to other instances where the community's input may be sought, and then discounted, "reinforcing unequal power relationships between health professionals and communities" (p. 253). Minkler (1997) stated that even programs committed to community participation through advisory boards and other processes may find themselves ignoring input and resorting to paternalistic actions because of predetermined projects, plans, funding guidelines, priorities and timelines. In Minkler's words, "recognition of the importance of self determination for communities, coupled with commitment to the concept of true partnership, must serve as guiding principles for ensuring meaningful community partnership" (p. 128).

Herbert and Irene Rubin (1992) developed a useful tool that community organizers can use in applying the principles of true community participation. It is referred to as the DARE criteria of empowerment and asks the following questions:

- Who determines the goals of the project?
- Who acts to achieve them?
- Who receives the benefits of the action?
- Who evaluates the actions? (p. 77)

Minkler (1997) suggested that when health professionals were able to respond to each of the four questions, with the words "the community," they were well on their way to achieving real, not symbolic, community empowerment and high-level community participation.

Drevdahl (1995) examined the challenges associated with community-level interventions for health professionals, specifically nurses, who, are traditionally trained to focus community interventions on the individual. She described a paradox, "in which improving a population's health is sought through nursing actions aimed at individual behaviours, rather than at larger social mechanisms that produce and support the behaviours" (p. 13). According to Drevdahl, "nursing for the most part has aligned itself with the dominant culture, repairing damaged seams in the social fabric rather than looking for the structural and foundational changes needed to effect change for oppressed groups" (p. 21). First, Drevdahl called for radical changes in nursing practice, which included community nurses engaging in critical discussions on the meaning of "community." For example, "How were they using the term? Was it inclusionary or exclusionary? Who were the target groups?" (p. 22). Second, nurses needed to identify strategies to work within the larger socio-political structures. This necessitated nurses thinking about ways of measuring change and empowerment at the community level (e.g., policy changes, effectiveness of community networks) as opposed to concentrating efforts only at the individual level. Third, nurses needed to understand the role power and control play not only in society, but also within themselves. Drevdahl stated that, "nurses should examine their own complicity in creating and supporting larger social structures and systems and their relationships and inequities" (p. 22).

2.14. Food Security

In an effort to determine why traditional prenatal health promotion programs have failed to positively influence the incidence of low birthweight in Canada, it is useful to examine the findings of Travers (1994, 1996, 1997a, 1997b) based on research describing the nutrition experiences of low income women in Halifax, NS. According to Travers (1997a), "if the social world is the source of nutritional problems then the solutions to these problems lie in social change" (p. 61). In 1994, Israel, Checkoway, Schulz and Zimmerman had also concluded that access to nutritious and affordable food in low income communities is not determined by the individuals residing within them, but by processes of production and distribution that reflect regional, national and international corporate and governmental interests (p. 150).

Travers argued that the traditional, but changing, emphasis of nutrition education on individualistic behaviour change strategies negates the role of social context in shaping behaviour. She warned that dogmatic nutrition education messages do not assist the disadvantaged in making healthy food choices. Rather, they foster a sense of inadequacy and guilt among those who can not live up to the standard (1997a, p. 59). Travers (1997a) called for a re-orientation of community nutrition education practice from an individual orientation to a social orientation. She cautioned that in transitioning from a behavioural to a socio-environmental approach, health professionals must not fall into the trap of conceptualizing health determinants (e.g., poverty) as a "barrier to healthy eating" or "a concrete wall over which people must climb in order to eat" (p. 59).

Tarasuk, Beaton, Geduld, and Hilditch (1998) undertook a study to assess the food insecurity and nutritional vulnerability of one subgroup of food bank users--women with young children. The results of interviews based on a sample of 153 women recruited from emergency food relief programs in Metropolitan Toronto, revealed that study participants were experiencing severe poverty, food scarcity, and deprivation. Although the extent of reported food insecurity varied widely among households, 93.5% reported some degree of food insecurity over the past 12 months. A significant number of adult interviewees reported experiences of food deprivation (i.e., hunger) in the past year. Further, 26.8% of women also reported that their children had experienced some degree of food deprivation in the past year. The authors emphasized that "the food deprivation documented in the study occurred *in spite of* the charitable food assistance women were able to obtain from food banks, and *in spite of* the host of other strategies employed to augment scarce household resources" (p.23).

Tarasuk et al. (1998) documented that women in households with severe food insecurity appeared to be at particular risk for nutrient inadequacies. The authors cautioned that while short-term consumption of sub-optimal diet is unlikely to have long-term health consequences, the reader should not assume that study participants' hardships related to accessing safe, nutritious, and culturally acceptable food for themselves and their families, are temporary.

The majority of women in the Toronto study were on social assistance--90% reported household incomes which were less than two-thirds of the Statistics Canada Low-income Cut-Offs. Additionally, 65% of the sample reported that they were lone parents. The data indicated that close to two-thirds of the participants were socially isolated (i.e., alone some, or most of the time), and many described themselves as being in poor health. It is interesting to note that 12% of study participants reported giving birth to babies of LBW, and an additional 12% reported that they had delivered a premature baby. Further, six women had given birth to children who had died in the first year (p. 14).

The authors concluded that extensive food insecurity among households on social assistance is indicative of the serious inadequacy of current social assistance rates. Further, the findings pointed to the inability of charitable food assistance programs, such as community-based food banks, to provide long-term, efficacious solutions to food insecurity. Tarasuk et al. (1998) called on Canadian policy makers to establish social assistance benefits at levels which ensure that low-income families are capable of meeting their essential needs.

2.15. A Socio-environmental Approach to Prenatal Health Promotion

Prenatal health promotion strategies enable women and their families to take control of and improve their health. According to Labonte (1994), this is accomplished through actions that foster personal empowerment and changes in the socio-political environment that will enhance opportunities for personal well-being, healthy pregnancies and healthy family functioning. A comprehensive health promotion program, based on a socio-environmental approach and described by Labonte (1993), has these elements:

- conceptualizes health as a positive state that is largely defined in one's 'connectedness' to one's friends, family and community;
- defines 'wellness' in psychological, social as well as physical terms;
- recognizes the important links between socioenvironmental risk conditions and health e.g., the links between poverty, poor health of the mother and poor birth outcomes;
- focuses on informal and formal support systems (family and friends as well as health and social service providers);
- challenges inequities in health such as those resulting from racism, sexism, violence and stereotyping;
- stresses primary prevention (creating healthy lifestyles) and health promotion (creating healthy living conditions);
- uses a mix of strategies that include community participation in all stages of program development and co-ordination, community mobilization, coalition building, advocacy for policy change, and political action;
- recognizes diversity and the influence of culture on community values and actions;
- supports community groups in their identification of issues, and in their ability to plan and implement strategies to mitigate concerns and resolve issues;
- considers success indicators to be improvements in the personal perception of health, strengthened social networks, and effective community group actions

> to create a more equitable social distribution of power and resources (pp. 33-35).

A socio-environmental approach to prenatal health promotion is consistent with the Jakarta Declaration (World Health Organization, 1998), in which peace, shelter, education, social security, social relations, food, income, empowerment for women, stable eco-system, sustainable resources use, social justice, and respect for human rights and equity are considered pre-requisites for health.

2.16. Recommendations for Action Based on the Literature

The rationale and purpose of prenatal programs must be broadened from a medical and behavioural approach to a health promotion approach designed to build supportive environments and increase people's control over their own health, for example, by preventing unhealthy birthweights. Multilevel risk conditions which adversely impact prenatal health (e.g., poverty, food insecurity and family violence) are best addressed through interagency and intersectoral collaboration, facilitation of group/community development, and coalition advocacy. Interventions to prevent low birthweight must mobilize support from family and friends; encompass support from peers and health professionals; and foster efficacy, empowerment, and esteem. A socio-environmental approach to prenatal health promotion will ensure that women have the opportunity to actively participate in the design and implementation of programs that address their priorities, and in discussion of potential policy changes pertaining to health and social issues.

Additionally, policy makers must ensure the basic needs of low-income individuals and their families (e.g., food, clothing, and shelter) are adequately met. Comprehensive, co-ordinated and collaborative policies are called for to ensure that disparities in health status are reduced and equity within the socioeconomic environment increased. Within the context of prenatal care, at-risk populations (e.g., low-income, socially isolated women and teens) must have easy access to conditions that provide adequate income, nutrition, support, appropriate medical care, advocacy and personal safety. It is evident from the literature that programs like the CPNP cannot compensate for seriously inadequate social programs.

Over 75% of participants in Winnipeg's HSMM reported that "it's hard for them to get enough food" (Wylie, 1998). Three-quarters of the participants stated that they used food banks on a regular basis, and just under half indicated that they needed to obtain food from relatives and friends. The food insecurity experienced by these participants is indicative of much broader insecurity in terms of access to a wide range of essential supplies and health/social services. It is not realistic to think that a single prenatal health promotion program can have a positive and sustainable impact on the lives of women living in poverty and experiencing social isolation. Tarasuk, Beaton, Geduld and Hilditch (1998) called for the development of national standards to guide provinces and municipalities in their restructuring of benefits so as to meet basic needs: "Without improved income support for families on social assistance and those struggling to support themselves in low-waged jobs, the nutritional health and well-being of family members will be jeopardised" (p. 24).

In summary, prenatal health promotion programs need to focus on the prevention of FAS/FAE and unhealthy birthweights. However, they must begin to address the broader determinants of health that place women and their families at high risk for abuse, dysfunctional family functioning, and poor mental, physical and spiritual health. Policy makers and service providers must work together with the community to address the social, economic and environmental risk conditions that influence whether or not a healthy baby will be born into a healthy family. The challenges to all stakeholders are enormous, but the societal risks associated with a failure to broaden our approach should not be under-estimated. The results of inadequate prenatal care are far-reaching: higher infant mortality rates, increased long-term health care costs associated with pre-term deliveries and low birthweights, and the persistence of health and social inequities among disadvantaged women and their families.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1. Introduction

Chapter 3 consists of an overview of the research design; a discussion of the issues associated with the study's trustworthiness; content on assumptions, delimitations, and limitations; and a description of relevant ethical considerations. The chapter concludes with the researcher's reflections on the study design and methods.

3.2. Critical Social Theory

Labonte (1994) stated that health care professionals must seek to understand the psychosocial and environmental contexts of the client's concerns or health problems:

> Unless professionals think simultaneously in both personal and structural ways, they risk losing sight of the simultaneous reality of both. If they focus only on the individual, and only on crisis management or service delivery, they risk privatizing by rendering personal the social and economic underpinnings to poverty and powerlessness. If they focus on the structural issues, they risk ignoring the immediate pains and personal woundings of the powerless and people in crisis. (p. 259)

Critical social research begins with understanding the experiences of program participants and attempts to explain their interconnectedness with the social environment. If researchers fail to locate their research activity in the same social world as the phenomena being studied, they risk being irrelevant to the lives and conditions of many persons (Eakin et al., 1996). Taking a reflexive approach towards knowledge and the research process helps researchers to recognize alternative ways of viewing reality and assists them in making explicit the underlying assumptions and ideology.

According to Travers (1997a), traditional nutrition education research and practice can "reproduce nutritional inequities by failing to question their root causes and by increasing the availability of resources usable only by those predisposed to healthy living" (p. 59). She suggested that the usefulness of traditional approaches--including nutritional screening, individualized assessment, and counseling--is negated by social and economic disadvantage. When practitioners rely solely on these traditional approaches, they run the risk of offending marginalized populations unable to afford the quantity and/or quality of protective foods. Additionally, they inadvertently further complicate and overwhelm their clients' already stressful lives by putting "on the table" more and more urgent problems that they must address and "buy into." Travers argued that an empowering nutrition education practice explores the social and environmental roots of nutrition inequities and works to address such issues as social isolation, low literacy skills, and poverty-induced food insecurity.

Little research has made explicit use of theories that examine the social world as the source of nutritional problems (Travers, 1997a; Achterberg & Clark, 1992). Nutrition inequities are defined as the food and nutrition challenges and/or concerns of marginalized groups that are related to social injustices. A theoretical approach that may be particularly useful in guiding the practices of health promotion practitioners to reduce nutrition inequities is a critical social science perspective (CSSP; Eakin et al., 1996). This approach consists of a series of reflexive questions designed to describe and explain the basic assumptions and ideologies underlying the way research problems and methodology are conceived. Additionally, a CSSP reveals the socio-political construction of research problems by recognizing the role of power and contradiction in all aspects of research. Eakin et al. (1996) maintained that the dialectical relationship between the formal and informal structures of society (institutions, social norms) and individual or collection action have to be understood in relationship to their social, political, and economic contexts.

A critical social approach includes asking tough questions to expose inequities; making meaningful connections with communities and working collaboratively to identify and solve health problems; establishing partnerships with others having common goals; and targeting strategies primarily at the collective, as opposed to the individual level (Stevens & Hall, 1992). Rather than presenting solutions and directing lifestyle changes, the health promotion practitioner's role is facilitative: assisting individuals and groups to critically reflect on the social and political factors that influence health, sharing expertise, and providing support. According to Stevens and Hall (1992), "by offering knowledge, support, and expertise to communities in ways and times that are relevant to their aims, we can assist them to bring about liberating changes" (p. 5).

These strategies require that practitioners have a broad understanding of the context of poverty in terms of the systemic forces that influence access to the prerequisites for good health (Reutter, 2000). Health Canada (1998, p. 8) described the complex and inter-related determinants of health in a position paper entitled "Taking Action on Population Health." With respect to the issue of poverty and its impact on prenatal outcomes, questions such as the following contribute to critical reflection: What are the trends in prenatal outcomes in relation to poverty? Who are the groups most at risk for poor prenatal outcomes and what are the reasons for this? How do Canadian prenatal outcomes compare with those in other countries and what accounts for these differences? Who has had access to prenatal resources/services and whose interests have been served by traditional approaches to programming? Are current policies and prenatal services improving or exacerbating the effects of poverty on prenatal outcomes? In addition to asking such critical questions, practitioners may also need to reflect on their own attitudes toward the economically disadvantaged, particularly in relation to the causes of poverty and the relationships among poverty, food insecurity, and prenatal outcomes. Chapters 7 and 8 of the thesis describe the critical reflection and collective action on the part of program staff, community partners, and participant women that resulted in the implementation of the HSMM Collaborative Outreach Model (Appendix C).

3.3. Justification and Strengths of a Case Study Approach

This study used qualitative research methods. To address complex human social interactions such as those that characterize HSMM, qualitative methodology is preferred. Miles and Huberman (1994) suggested that there can be problems if a researcher assumes that complex phenomena can be understood by treating them as if they can be "broken up into a temporal chain of events, all connected by determinate casual relations" (p. 26). The dynamics and complexities of human interaction would be lost in methods that attempt to isolate variables and determine linear casual relationships. Qualitative research methods offered an attractive alternative for this study because they enabled understanding of human behaviour in greater depth than is possible from the study of surface behaviour; from "paper and pencil" tests; and from highly structured, formal interviews. As Guba (1981) and Clandinin and Connelly (1990) indicated, qualitative research encompasses multiple realities, which interact to form personal and practical knowledge. However, the choice of a qualitative research method does not negate the need for quantitative data to help direct an investigation. Given that a plethora of quantitative data exists, an effort was made to review the relevant literature and to use the relevant findings to inform a qualitative case study on prenatal health promotion.

Merriam (1988) maintained that several characteristics of qualitative research are worth emphasizing as they figure predominately in case study research. First, qualitative researchers are primarily concerned with *process* (e.g., natural history of the activity or event under study) rather than outcomes or products. Second, qualitative researchers are concerned with *meaning* (how people make sense of their lives, what they experience, how they interpret these experiences, and how they structure their social world). Third, the researcher is the *primary* instrument for data collection for analysis; "data are mediated through this human instrument, the researcher, rather than through some inanimate inventory, questionnaire or machine" (p. 19). Fourth, case study research usually involves *fieldwork*, implying that one must physically go to the people, setting, site, and institution in order to observe behaviour in its natural setting.

Also, Stake (1994) suggested that different researchers have different purposes for using case studies. Given that the over-arching goal of this research was to more fully understand the day-to-day operations of HSMM, an intrinsic multi-site case study approach was used. The primary purpose of the research was not to generate theory, nor was it to understand an abstract construct or generic phenomenon. Rather, the primary interest of the researcher was to understand HSMM, "in all its particularity and ordinariness" (Stake, 1994, p. 237).

Justification for the intrinsic case study approach was based on the fact that the knowledge gained from case study is different from other research knowledge in four important ways identified by Stake (1994). First, case study research is more concrete and "resonates with our own experience because it is more vivid, concrete and sensory than abstract" (p. 236). Second, because case study knowledge is more contextual, and because our experiences are rooted in context, the knowledge is distinguishable from other abstract formal knowledge derived from other research designs. Third, because the knowledge is more developed by reader interpretation, "readers bring to a case study their own experience and understanding which leads to generalizations to be part of the knowledge produced by case studies" (p. 236). Fourth, because it is based on reference populations determined by the reader, unlike traditional quantitative research, the reader is able to extend generalizations to reference populations. Patton (1987) suggested that case studies were particularly useful when the researcher needed to understand a particular problem, or situation, in great depth, and where one can identify a unique case that is rich in information. Additionally, Patton recommended a case study approach when the researcher sought to capture individual differences or unique variations from one program experience to another. According to Patton (1987), the more a program aims at individualized outcomes, as compared to common outcomes for all participants, the more appropriate it is to use qualitative case methods (p. 19).

This was not an ethnographic study but used ethnographic research methods to examine human action in natural rather than in experimental conditions. Data were generated using features of narrative inquiry (Denzin, 1997; Clandinin & Connelly, 1990). Narrative inquiry is both phenomenon and method. Clandinin and Connelly stated that "the educational importance of this line of work is that it brings theoretical ideas about human life as lived to bear on educational experiences as lived" (p. 3). The use of story telling in qualitative research concerns "making meaning from personal experience" (p. 4). In this case study, story telling gave voice to the experiences of participant women, program staff, community partners, and key informants in HSMM. Giving voice and recognition to the lived experiences of program participants and community partners is of particular importance when new programs are being developed and where new health promotion approaches, methods, and practices are being advanced and refined.

Ethnography attempts to preserve the "uniqueness" of the case to accurately represent the particular situation. Giacomi, Mosher, and Seaton-Wall (1993) stated that that "the ethnographic approach with its emphasis on 'natives' point of view, holism, and natural settings, provides a unique perspective to bring to bear on understanding users' work activities" (p. 123). Observing, conversing with program staff and community partners as they went about their work, spending time discussing observations, and learning in situ all contributed to the careful descriptions of the reality under study. In this regard, Scott (1996) stated, "that descriptions of social reality are incomplete if they do not take account of the views and perceptions of social actors" (p. 144).

3.4. Role of the Qualitative Case Researcher

Stake (1995) summarized the major conceptual responsibilities of the qualitative case researcher as follows:

1. Bounding the case, conceptualizing the object of study;
2. Selecting phenomena, themes or issues – that is, the research questions to emphasize;
3. Seeking patterns of data to develop the issues;
4. Triangulating key observations and bases for interpretation;
5. Selecting alternatives to pursue;
6. Developing assertions or generalizations about the case. (p. 236)

Point 1--bounding the case--differentiates these steps from other approaches to qualitative research. According to Creswell (1998), "the researcher must decide what bounded system to study, recognizing that several might be possible candidates for this selection, and realizing that the case itself, or an issue, for which a case or cases are selected to illustrate, is worthy of study" (p. 63).

3.4.1. Bounding the Unique Case

In bounding the case, the first criterion should be to maximize what we can learn (Stake, 1995). According to Stake, "the more the intrinsic interest in the case, the more we will restrain our curiosity and special interests and the more we will try to discern and pursue critical issues to the case" (p. 4).

HSMM is a city-wide program, operating from eight community-based sites. An in-depth examination of the day-to-day operations of the eight sites would quickly have generated more information than could be managed given the scope of a PhD thesis. It is important to note that any best possible selection of sites from a balanced design would not give the researcher compelling representation for the city as a whole, and certainly not a statistical base for generalizing about interactions between activity and site characteristics. Several desirable sites had to be omitted by the bounding process. "While balance and variety are important, the opportunity to learn is of prime importance" (Stake, 1995, p. 5). In this case study, the researcher involved the HSMM Steering Committee in the bounding process. In selecting two, of a possible eight HSMM sites, the Steering Committee and the researcher considered the following site-specific factors: stability of the program; work-load issues; staff and/or community partners' relationships with facility personnel; dynamics of the HSMM team; and, the perceived capacities of team members and HSMM "clients" to actively participate in the study. Sampling operations described in Section 3.8 served to further define the case.

This qualitative research study focused on two program sites, both well established within the HSMM program. In this thesis, pseudonyms are used to represent the two sites. The demographics of the participants attending both sites were relatively similar with one exception. There were more immigrant/refugee women attending the Willow Community Centre site in comparison to the Evergreen Community Centre site. Many of the immigrant/refugee women lived in a short-term, low-income housing complex located in close proximity to the HSMM site. Translation services were provided on a regular basis at the drop-in sessions at the Willow Community Centre site. They were also required during the focus group interview held with participant women at that site, only. The nature of the communities surrounding the two HSMM sites, including racial, ethnic, and economic mix were not remarkably diverse.

Staffing configurations differed between the two sites with one site (Evergreen Community Centre) relying on HSMM for dietitian and peer outreach services and support, and the other site (Willow Community Centre) relying on a community partner, Health Action Centre, for dietitian services. Outreach services at the Willow Community Centre site were provided by a HSMM peer outreach worker. Drop-in sessions at both sites were co-facilitated by community/public health nurses employed by the Winnipeg Community and Long Term Care Authority (WCA).

3.4.1.1. Site #1 – Evergreen Community Centre

The Evergreen Community Centre was a community-based recreation centre owned and managed by The City of Winnipeg (Parks and Recreation Department). The site attracted 25 to 30 women per drop-in session. The majority of the women attending the drop-in lived in the inner-city neighbourhood adjacent to the Centre and did not require transportation to the site. The facility was new, comfortably furnished, and ideal for conducting informal "talks." The modern kitchen was nicely designed and well equipped for preparing and serving low-cost nutritious foods and snacks. The Centre had excellent child-care facilities accessible to HSMM participants (providing the program arranged for volunteer child-care workers). Parks and Recreation staff were on-site during operating hours and they were very supportive of the prenatal health promotion program. HSMM had been operating from the Evergreen Community Centre for approximately two years.

Dietitian services and peer outreach supports were provided by HSMM. The WCA contributed public health nursing services, as did an inner-city community health clinic located in close proximity to the Evergreen Community Centre. Program staff reported that the interdisciplinary team functioned effectively and staff appeared comfortable with their roles and responsibilities. HSMM staff described a very positive working relationship with partner organizations affiliated with the site.

3.4.1.2. Site #2 – Willow Community Centre

The Willow Community Centre was a well-known community-facility, owned and managed by The City of Winnipeg (Parks and Recreation Department). Originally, the Willow Community Centre was a privately owned industrial warehouse that was purchased by the City and converted into a community centre in the early 1990s. The site attracted 15 to 20 women per drop-in session. The majority of the women attending the drop-in lived in the inner-city neighbourhood adjacent to the Willow Community Centre and did not require transportation to the site. Program staff observed an increasing number of immigrant/refugee women attending the HSMM drop-in sessions over the past two years. Recently, Iranian, African, and South American women, and their children, have attended the drop-in on a regular basis. This has resulted in staff relying on translators at the drop-ins with increasing frequency. Additionally, prenatal print resources have been translated in a variety of languages to meet the needs of HSMM participants. The Willow Community Centre meeting rooms were spacious, however the kitchen was small and poorly equipped making communal food preparation challenging. Child-care was provided on site by HSMM volunteers. Parks and Recreation staff were available during drop-in operating hours to address facility concerns.

Peer outreach services at the Willow Community Centre drop-in sessions were provided by HSMM. WCA contributed community/public health nursing services to the drop-in sessions. A community health clinic located in close proximity to the Willow Community Centre contributed the services of a dietitian to the bi-weekly drop-in sessions. The HSMM staff complement has been remarkably consistent over the last two and-a-half years of operation. The working relationship with community partners at the site has evolved well and was described by program staff in very positive terms.

3.4.2. Focus on Prenatal Care Versus Infant Care

In the spring of 1999, HSMM received additional funding from the Manitoba government (Department of Child & Family Services) to expand services to address postnatal issues, with a focus on infant/preschool nutrition and nurturing. This case study did not address the new postnatal program (named "Baby Steps"), which is in the early stages of development and implementation.

3.4.3. Distinction Between Case Study and National CPNP Evaluation

The national CPNP evaluation framework (Appendix A) addresses these four broad priority areas:

1. Relevance of the program--e.g., How does the CPNP complement or expand upon other prenatal programs addressing the same issue at the provincial, municipal and community levels?
2. Implementation process--e.g., Has the CPNP reached the intended target groups?
3. Program success --e.g., What evidence is there that CPNP projects and project activities have had the desired effect on pregnancy outcomes, including birthweight and breastfeeding rates and duration?
4. Cost effectiveness--e.g., is there any early evidence about the cost effectiveness of CPNP? (Barrington & Glacken, 1998a, p. 4).

The national evaluation tools are the Individual Project Questionnaire (IPQ) and the Individual Client Questionnaire (ICQ). Data from these instruments are housed in the CPNP Evaluation Database, a relational database developed specifically for the national CPNP evaluation.

While the researcher used the CPNP IPQ and ICQ evaluation reports as background information important in adding breadth to the study, there was no intention or interest in duplicating areas of investigation. Rather, the quantitative data from the national CPNP evaluation complemented the highly qualitative, in-depth research findings related to the lived experiences, perceptions, feelings, and knowledge of HSMM participants, staff, and program partners.

3.5. Data Collection Methods

Stake (1995) suggested a general analytic strategy to develop a descriptive framework for organizing the case study. He refered to case study "as a study of the particular" and suggested that the researcher gather data on "the nature of the case; its historical background; the physical setting; other contexts including economic, political, legal and aesthetic; other cases through which this case is recognized; and those informants through whom the case can be known" (p. 237).

Unlike experimental, survey, or historical research, case study does not claim any particular methods for data collection or analysis. Regardless of the type of case study utilized, data collection extensively draws on multiple sources of information. The research design for this study included participant observation, individual interviews, focus group interviews, as well as a comprehensive review of documents and physical artefacts. Yin (1989) stated that the unique strength of the case study is its ability to deal with a full variety of evidence. Multiple data collection techniques acted as an internal validity/credibility check (triangulation), such that data obtained by one method could be checked against data obtained by another method (Miles and Huberman, 1994, 1999).

3.5.1. Participant Observation--HSMM Women

The study population included regular HSMM participants attending 2 pre-selected drop-in sites. Approximately 30 participants at the Evergreen Community Centre site and 20 participants at the Willow Community Centre site were included (n=50). Women were observed throughout their involvement in HSMM--they were asked by the researcher if they consented to be part of the study after they had been accepted into the program. Participants observed during the drop-in sessions were asked by the researcher to sign a consent form (Appendix D).

The researcher became a participant observer by "sitting in" on the drop-in sessions scheduled on a bi-weekly basis at both sites. The researcher observed three drop-in sessions at each site for a total of 24 hours of observation. To increase the reliability of the observations, the researcher made short notes at the time and expanded the notes as soon as possible after each session. The notes documented both verbal and non-verbal interactions as recommended by Patton (1987). A fieldwork journal was kept to record problems or ideas as they arose; it also served as a provisional record of analysis and interpretation (Silverman, 1993).

The researcher offered to assist with tasks such as setting up the room, making coffee, preparing and serving nutritious snacks, cleaning up the food preparation area and assisting with childcare, if necessary. The researcher's offer of assistance was important, because, as Marshall and Rossman (1995) have stated "when people adjust their priorities and routines to help the researcher, or even just tolerate the researcher's presence, they are giving of themselves" (p. 71). Reciprocity on the part of the researcher demonstrated to HSMM participants a sense of indebtedness.

3.5.2 Participant Observation–HSMM Professional Staff/Outreach Workers

Community nurses, dietitians and peer outreach staff assigned to the sites were observed by the researcher in a variety of settings to learn more about behaviour and meanings attached to those behaviours. The settings included formal routines (de-briefing sessions after drop-in sessions and staff meetings) as well as informal routines such as lunch and coffee breaks, preparation periods at drop-in sessions, and other events during which professionals interacted with peer support staff. This type of observation provided data on collegiality, goals and expectations, and the knowledge base for "teaching." Additionally, norms regarding how professional staff related to peer outreach worker became evident.

The researcher received written approval from the HSMM Steering Committee to observe program staff associated with the two neighbourhood sites (Evergreen Community Centre and Willow Community Centre). Formal letters of support for the research were received by the Chair of the Steering Committee and by the CEO of

Dietitians of Canada, the program sponsor. The Manager of HSMM offered the researcher temporary office space at the program's central office located at 400 Edmonton Street, Winnipeg. The researcher's close proximity to program staff facilitated observation. HSMM staff were introduced to the researcher at a meeting specifically designed to explain the purpose of the research. The staff meeting was scheduled to coincide with the researcher's arrival in Winnipeg and ensured that staff members were aware of the researcher's presence as soon as possible. The meeting also provided HSMM staff with an opportunity to ask questions of the researcher.

3.5.3. Focus Group Interviews

Focus group interviews were conducted with 12 participant women at the Evergreen Community Centre site and 11 participant women at the Willow Community Centre site (n=23). Participant women self- selected and had no obligation whatsoever to participate in the focus group interviews. The researcher scheduled the focus groups at each site, after having observed three drop-in sessions. There is normally a "free" week between bi-weekly drop-in sessions--the focus group interviews were scheduled to take place on the "free" week so as not to compete with the drop-in sessions. The focus group sites were easily accessible to women and transportation was provided, as necessary. A light meal (pizza) was served and complimentary child-care was provided on-site. Additionally, participants were given an honorarium for their time and effort.

At each focus group interview, a trained facilitator conducted the interview --she was assisted by the researcher. The focus group facilitator was asked to sign a consent form (Appendix E). During the introductory portion of the group interviews, the facilitator/interviewer clarified the objectives of the study, provided a brief overview of the procedure, and assured participants that all comments were confidential and that their names would not be used in the report. Focus group participants were asked to sign a consent form (Appendix F).

The purpose of the focus group interviews was to elicit women's experiences in HSMM. The rationale for the use of groups was based on the assumption that people who share a problem "may be more willing to talk about it amid the security of others with similar problems" (Achterberg, 1988, pp. 246-247). According to Travers (1997b), "group interviews offer the advantage of efficiency, social support and critical education"

(p. 347). In total, the trained facilitator conducted two focus group interviews of one-and-a-half to two hours in length. Interviews were audiotaped and then transcribed for later analysis. Focus group participants were asked individually by the researcher, prior to the group interview, if they would like to review drafts from the audiotaped interviews for accuracy, and if necessary, revision or inclusion of additional data (Appendix G).

A semistructured interview guide was developed for the purpose of organizing discussions thematically. Questions were exploratory, open-ended, and accompanied by probes. They were pilot-tested in preparation for the first formal focus group interview. The questions focused on several areas: perceptions and satisfaction with the program; concerns, beliefs in control, and feelings about the future; relationships with friends and family; participation in drop-in sessions; perception of community strengths and problems; and actions related to individual and/or community change (Appendix H).

3.5.4. Individual Interviews

Semi-structured interviews were conducted with program staff and community partners assigned to the two HSMM sites (n=10). During the introductory portion of the individual interviews the interviewer clarified the objectives of the study, and provided a brief overview of the procedure. Participants were assured that their names would not be used in the final research report and they were asked to sign a consent form (Appendix I). Individual interviews were used to ensure that program staff and community partners were free to be candid in discussing the strengths and weaknesses of the program. Interviews were conducted in locations easily accessible to staff and an effort was made to ensure that the meeting spaces were both private and comfortable.

Each interview took approximately one-and-a-half hours and was scheduled at a time that was convenient to the interviewee. A semi-structured interview guide was developed to organize discussions thematically. Questions were exploratory, open-ended, and accompanied by probes. They focused on several areas: perceptions and satisfactions with the program; nature of interactions between professional staff, peer outreach worker, and participants; issues and tensions arising from the peer outreach workers' practices with marginalized women and their families; and the effects of interdisciplinarity on the norms and values of the practitioners' professions (Appendix J). Questions were pilot-tested in preparation for the first formal individual interview. All of the individual interviews were tape-recorded and transcribed.

Respondents were asked to review drafts from the audiotaped interviews for accuracy and, if necessary, revision or inclusion of additional data (Appendix G) After reviewing transcripts and field notes, some HSMM team members were subsequently contacted to clarify points raised in the interviews. These steps helped to increase the accuracy of the transcripts of the interviews.

3.5.5. Elite Interviews

Elite interviewees are among the influential, the prominent, and/or the well-informed people in the community and were selected for their expertise in areas relevant to the research. Marshall and Rossman (1995) stated that elite interviewees "respond best to inquiries about broad areas of content and to a high proportion of intelligent, provocative, open-ended questions that allow them to use their knowledge and imagination" (p. 83). Elite individual interviews were scheduled with 11 key informants. During the introductory portion of the individual interview, the researcher clarified the objectives of the study and provided an overview of the procedure. Participants were assured that their names would not be used in the final research report and they were asked to sign a consent form (Appendix K). Informants included the manager of HSMM, Chair of the Steering Committee, key representatives of the funding agency and partner agencies/organizations, and others identified through a "snowball sampling" technique (Patton, 1987).

A semi-structured interview guide was prepared to organize the discussion thematically. Each elite interview took approximately one-and-a-half hours. Questions were exploratory, open-ended and accompanied by probes. They focused on several areas: experiences with the program; perceptions and satisfaction with the program; factors influencing the decision of community partners to participate in the program; and actions related to individual or community change (Appendix L). Questions were pilot-tested in preparation for the first elite interview.

All of the elite interviews were tape-recorded and transcribed. Respondents were asked to review drafts from the audiotaped interviews for accuracy, and if necessary, revision or inclusion of additional data (Appendix G). After reviewing transcripts and field notes, some key informants were subsequently contacted to clarify points raised in the interviews.

3.5.6. Document Review

The researcher supplemented participant observation, interviewing, and focus group meetings with the gathering and analyzing of documents. Marshall and Rossman (1995) stated that the review of documents is an unobtrusive method, "rich in portraying the values and beliefs of participants" in the two settings (p. 84). Data gathered was linked to research questions developed in the conceptual framework of the study. Archival records related to program priorities, meeting notes, year-end reports, newsletters, newspaper reports, and announcements helped in understanding the setting, as well as the group being studied.

3.5.7. Physical Artifacts

A study of photographs, scrap books, videos, resources, handicrafts, and recipe books produced by the two HSMM sites provided a visual record of natural events, processes and products.

3.6. Principles of Data Collection

The benefits of the data collection methods described above can be maximized if the following principles are used. Yin (1989) stated that these three principles, when used properly, could help to establish the construct validity and reliability of case study research (p. 95):

3.6.1. Principle 1–Using Multiple Sources of Evidence

The use of multiple sources of evidence allows the researcher to address a broader range of historical, attitudinal, and observational issues. Yin (1989) maintained that the most important advantage of using multiple sources of evidence was the development of converging lines of inquiry--the process of triangulation. In this way, the potential problems of construct validity could also be addressed, "because the multiple sources of evidence essentially provide multiple measures of the same phenomenon" (p. 97). As described in Section 3.5, the case study research on HSMM considered multiple sources of information.

3.6.2. Principle 2–Creating a Case Study Database

The second principle, concerned with organizing and documenting the data used in case study research, called for two separate collections of documentation: (a) the data or evidentiary base, and (b) the report of the investigator written in article, report or book form. Yin (1989) stated that it was very important to develop a formal, retrievable database to enable other researchers to review the evidence directly and not be limited by written reports (p. 99). In this manner, Yin suggested that adhering to Principle 2 would markedly increase the reliability of case study research. As described in Section 3.9, in this study, data analysis partially involved a computerized database. Additionally, this thesis serves as the final report of the investigator.

3.6.3. Principle 3–Maintaining a Chain of Evidence

Maintaining a chain of evidence will increase the reliability of the information in a case study. The principle, as described by Yin (1989), was to allow an external observer--the reader of the case study--to follow the derivation of any evidence from initial research question to ultimate case study conclusion. According to Yin, "the observer should be able to trace the steps in either direction (from conclusions back to initial research questions or from questions to conclusions" (p. 102). The process should be tight enough that no original evidence is lost, through carelessness or bias, and therefore fail to receive appropriate attention in considering the "facts" of the case. In the opinion of Yin (1989), if these objectives were achieved, the case study would have addressed the methodological problem of determining construct validity, thereby increasing the overall quality of the case. The processes used to maintain a chain of evidence in this study are described in Section 3.9.

3.7. Selection of Research Participants

According to Marshall and Rossman (1995) the ideal site is one where (a) entry is possible; (b) there is a high probability that a rich mix of the processes, people, programs, interactions, and structures are present; (c) the researcher is able to build trusting relationships with the participants in the study; and (d) data quality and credibility of the study are reasonably assured (p. 51). Citing Dobbert (1982), the authors stated, "To justify a sample, one must know the universe and all of its relevant variables--an impossible task. Generally, the best compromise is to include a sample with reasonable variation in the phenomenon, settings, or people under study" (p. 50).

Gaining access to sites--requiring formal approval--"requires time, patience, and sensitivity to the rhythms and norms of a group" (Marshall and Rossman, 1995, p. 64). In order to begin the process of establishing a research design, the researcher made two preparatory trips to Winnipeg, in January and March 1999. The specific focus of the study emerged after pre-study visits and conversations with program staff. As part of the process, the researcher presented the research proposal to the HSMM Steering Committee for feedback on October 5, 1999.

The researcher was sensitive to the need to establish trust with participants, program staff, and members of the Steering Committee. The researcher was involved in the initial development of HSMM and the recruitment and selection of program staff between 1995-1996. In negotiating new relationships, and re-establishing old relationships with the program manager and staff, the researcher was aware of the need be flexible and patient as the terms and conditions of these relationships were re-negotiated over time.

Patton (1987) identified three possible kinds of sampling errors or distortions that can arise in qualitative research:

> (a) there may be distortion in situations that were sampled for observation (since it is seldom possible to observe all situation); (b) distortions introduced by the time periods during which observations took place--that is, problems of temporal sampling; and (c) the findings may be distorted because of selectivity in the people who were sampled either for observations or interviews. (p. 162)

The strategies discussed in Section 3.8 help to minimize these sampling errors, identified by Patton (1987).

3.8. The Use of Purposeful Sampling

In an effort to select information-rich cases for study, purposeful sampling was used. By focusing in depth on understanding the needs, interests and motivations of participants and staff, the researcher learned more than by gathering a little information from a large group of a statistically significant sample. The original research design was based on the strategy of homogenous sampling (Patton, 1987). This strategy involved picking a small homogenous sample where there was not expected to be a great deal of participant and/or program variation.

The rationale for homogenous sampling was based on the researcher's consideration of the following factors. First, all of the study participants were "enrolled" in the HSMM program at the two sites. Statistical information gathered on participants (May 1999), and discussed earlier in the thesis, suggested that there was considerable common ground with respect to income, education and some self-reported lifestyle behaviours of participant women. Second, the HSMM "curriculum" was relatively consistent from site to site (e.g., prenatal topics addressed, resources shared with participants, recipes featured in hands-on cooking sessions, use of videos and other teaching aides etc.).

In bringing together people of relatively similar backgrounds and experiences to participate in group and individual interviews, the researcher hoped to generate high-quality descriptive information about major program evaluation issues which affected them. Participants were asked to self-select for enrolment in focus groups. The researcher orally extended an invitation to all drop-in participants a week prior and participants were asked to informally "register" so that arrangements for food, child-care and transportation could be made. Focus group participants were contacted by phone the day before in order to confirm their participation.

Although the original research design was based on a small homogeneous sample of participant women, in reality, there proved to be significantly more heterogeneity in the sample than anticipated. This was largely attributed to the significant number of immigrant/refugee women attending the HSMM drop-in sessions at the Willow Community Centre site, in comparison to the Evergreen Community Centre site. In fact, seven of the 11participants in the focus group interview at the Willow Community Centre site did not speak English and participated in the interview with the assistance of a trained interpreter. While all focus group participants (n=23) were "enrolled" in HSMM, there were considerable unanticipated differences among participants with respect to age, race, cultural background, and length of exposure to the program.

According to Patton (1987), a great deal of heterogeneity can be problematic because individual cases are so different from each other. The author defined maximum variation sampling as "a strategy for purposeful sampling that aims at capturing and describing the central themes or principle outcomes that cut across a great deal of participant or program variation" (p. 53). In this study on HSMM, the unanticipated variation in sampling was originally conceived by the researcher as a weakness in the study design. However, in retrospect, the heterogeneity of the sample of participant women became a strength of the study design. The data collection and analysis emerging from the sample of significant diversity revealed two kinds of findings: (1) high-quality, detailed descriptions of two HSMM sites which were useful for documenting uniqueness; and, (2) important patterns common to both sites and which derived their significance from having emerged out of heterogeneity" (Patton, 1987, p. 53).

3.8.1. Snowball Sampling to Identify Key Informants

This approach was used to identify information-rich key informants. The process began by asking program staff, "Who knows a lot about . . . ?" And, "Who should I talk to . . . ?" Those people and events recommended as valuable by a number of key informants takes on special importance. Patton (1987) stated that the process will initially diverge as many valuable sources are recommended, then converge as a few key names get mentioned over and over again (p. 56).

3.9. Data Analysis

Data analysis was not an event that had a clear beginning and ending. Rather, inquiry was an ongoing process of probing for meaning, conceptualizing, re-conceptualizing, testing for meaning, and seeking verification. In this study, the researcher kept a journal during the data-gathering process to provide a history or path by which themes could be identified, probed for further understanding and, if necessary, interpretation sought. The constant reflection upon the research process gave greater explanatory power to the analysis. Qualitative data analysis is best accomplished when the researcher holds conclusions "lightly," seeking meaning from the data collected. Miles and Huberman (1994) stated that

> From the start of data collection, the qualitative analyst is beginning to decide what things mean--is noting regularities, patterns, explanations, possible configurations, casual flows and prepositions. The competent researcher holds these conclusions lightly, maintaining openness and scepticism but the conclusions are still there inchoate and vague at first then increasingly explicit and grounded to use a classic term of Glaser and Strauss. (p. 11)

Two strategic methods employed by the researcher to reach new meanings about this case was through "direct interpretation of the individual instance and through aggregation of instances until something can be said about them as a class" (Stake, 1995, p. 74). In Stake's words, even with intrinsic case study "the researcher sequences the action, categorizes properties, and makes tallies in some intuitive aggregation" (p. 74).

Marshall and Rossman (1995) stated that analytic procedures fall into five modes (p. 113). These include organizing the data; generating categories, themes and patterns; testing the emergent hypothesis against the data; searching for alternative explanations of the data; and writing the report. Each phase of data analysis entails data reduction as the reams of collected data are brought into "manageable chunks," and interpretation as the researcher brings meaning and insights to the words and acts of participants in the study.

When a case approach is used in qualitative analysis, Patton (1987) recommended that the first step consist of pulling together all of the raw data relevant to the specific case. The second step--constructing a case record--requires the researcher to condense, organize, classify, and edit the raw case data into a manageable package. The case record is then used to write a case study narrative, described as "a readable, descriptive picture of a person or program that makes accessible to the reader all of the information necessary to understand that person or program" (p. 149). Once the case study narrative on HSMM had been organized and written, the researcher used various strategies to further analyze and interpret the data.

In this case study, interview data were first checked for accuracy by reviewing the interviews while listening to the original tape-recorded interviews. Transcripts were then re-read several times to provide a more over-arching perspective of the ideas and observations provided by participant women, program staff, community partners, and key informants. Marshall and Rossman (1995) have described data analysis as "the process of bringing order to structure and meaning to the mass of collected data" (p. 111). Data analysis according to Patton (1987) is further complicated by the lack of "a precise point at which data collection ends and analysis begins" (p. 144).

While there is "undoubtly no consensus" concerning the analysis of collected data, Creswell (1998) suggests that there are common practices for "winnowing" the data collected in qualitative research (p. 140). In this case study, analysis of the data involved reviewing ideas, observations, and impressions arising from the collected data. Data analysis followed a sequence of steps which rather than proceeding in a linear manner, often resulted in a complex process where one step led to the next while at the same time also led back to the proceeding step(s). Cresswell (1998) defined this process as a "data analysis spiral" (p. 143).

Field notes and transcripts were analysed for common explanations, patterns, categories, and agreements. Preliminary coding involved searching for both similarities and differences among the data. Patterns were sought and categories identified on a matrix. Categories were further divided into subcategories based on a more refined analysis of the data. Categories were sorted into patterns based upon the semi-structured interview question categories. Hypotheses were formed and tested against the data collected. Categories and sub-categories were also sorted against the major and specific research questions. Themes were identified based on categories and their interconnectedness to research questions.

The use of qualitative data analysis software (NUD*IST 4.0) allowed specific or random searches for common words, phrases, or terms that assisted in connecting tentative themes to transcripts and field notes. Documents and physical artefacts were examined to provide further support to the commonalities, contrasts, and conceptual themes. Of further assistance in the analysis of the data was the opportunity to generate graphs of categories, subcategories, themes and impressions within NUD*IST 4.0 which allowed a visual representation upon which to test understandings with colleagues and peers. Visual mind maps and charting were used to check for connections and relationships among the observations and experiences of interviewees.

Throughout the data analysis and writing phases of this research, peer review of results was important. Notions about prenatal health promotion, hypotheses, observations, and preliminary findings were frequently tested against the opinions of others in the field, and with some of the study participants. Living with the research data, reviewing hunches, and reflecting upon impressions of the data collected also contributed to an overall understanding of the functioning of HSMM.

Consistent with the advice of Patton (1987), the researcher brought closure to the process of qualitative data analysis when

> sources of information had been exhausted, when sets of categories had been saturated so that new sources led to redundancy; when clear regularities had emerged that felt integrated, and when the analysis began to overextend beyond the boundaries of the issues and concerns guiding the analysis. (p. 154)

3.10. Trustworthiness of the Study

The trustworthiness of a study refers to the extent to which the results were accurately derived from an appropriate inquiry process (Guba, 1981). According to Guba (1981), trustworthiness is established when the results are credible, dependable, and confirmable, and when the transferability of the results is clearly outlined. Each aspect of naturalistic research confirms the rigor of the research and contributes to the confidence that a research study has value. Therefore, the researcher must be able to establish mechanisms to assure the credibility, transferability, dependability, and confirmability of the research process and results.

3.10.1. Establishing Credibility

Credibility is one criterion for establishing the truth value of a naturalistic inquiry (Guba, 1981). According to Guba (1981), credibility is established by demonstrating that the researcher's findings accurately represent the constructed realities of the study participants. The techniques that this researcher used to verify the credibility of this study included member checking, peer debriefing, negative case analysis, and progressive subjectivity (Guba, 1981).

3.10.1.1. Peer Debriefing

During the periods when the researcher was not in Winnipeg, she had an opportunity to debrief with experienced qualitative researchers as well as with peers versed in naturalistic inquiry. Guba (1981) recommended debriefing as a method of keeping the researcher's biases in check. Additionally, debriefing was of assistance in exploring emerging insights. For example, debriefing assisted the researcher in determining whether the questions raised during the interviews were appropriate in relation to the purpose of the study.

3.10.1.2. Member Checks

Glesne and Peshkin (1992) suggested modes through which qualitative data could be validated, and trustworthiness established. One of these modes included asking respondents if they were interested in reviewing drafts of the audio-taped interviews for accuracy and, if necessary, revising or including additional data. In this research study, the researcher mailed a transcript to informants within four to six weeks of the interview. This process, known as member checking, allowed informants to remove information from the transcript that could potentially be harmful if used by the researcher. Additionally, the informant was able to clarify statements, as necessary.

3.10.1.3. Negative Case Analysis

Negative case analysis involves challenging the researcher's working hypothesis with evidence that does not fit with the emerging or uncovered patterns (Guba, 1981). For example, during an interview one respondent was quite critical of HSMM's approach to participant women's use of alcohol and/or drugs. However, when returning the transcript of the interview to the researcher, the respondent had "softened" her original response considerably. The researcher examined information from the individual respondent that challenged the working hypotheses by analysing both the original and the modified transcripts to review the contexts of the statements. The researcher then contacted the respondent by telephone to ensure that the intended meanings were clear.

3.10.1.4. Progressive Subjectivism

Progress subjectivism is a technique for monitoring the researcher's developing construction (Guba, 1981). The goal is to provide evidence that the researcher's interpretation has emerged from the data and is fitting with the respondents' own constructions. The researcher used a journal to partially account for progressive subjectivism. Journal notations recorded pre-conceived notions of what the researcher might find in the study. These notes, recorded at regular intervals throughout the study, were later cross-referenced with the transcripts of the interviews.

Glesne and Peshkin (1992) stated that the researcher must become aware of personal biases, and the importance of practicing reflexivity. This involved asking questions, such as the following. Have I formed, or do I have special relationships that may influence or colour the interpretation of the data obtained during the act of research? Or, have my observations or selection of participants been influenced by professional biases? When the researcher questions personal propensities to particular orientations, the process contributes to greater confidences by readers that the research will be credible. The ability of the researcher to be aware and displace bias also contributes to the trustworthiness of the data. Section 3.14 outlines the researcher's assumptions and some personal biases pertaining to the case study on HSMM.

3.10.2. Establishing Transferability

Transferability refers to the extent which the findings of one study can be applied to another situation (Guba, 1981). For example, staff in another CPNP project might consider whether the results of this study are relevant to their project. People will require information on the context of the study in order to establish whether the findings are applicable to their own situation. To assist others in assessing the transferability of this study's results, the researcher used the technique of thick description (Geertz, 1973). The researcher provided rich, detailed descriptions of the settings of the two pre-selected sites, the background of HSMM, the informants, and the process of informant selection.

3.10.3. Dependability

The study results will be considered dependable only if there is evidence that the results have emerged from a rigorous and logical process of data collection and analysis. During a naturalistic inquiry, the researcher explored a number of interpretations about the data. The research methods were modified as new insights were gained. To assure potential users of the study's results, the researcher established an audit trail. This trail made it possible to arrange for a dependability audit, should one be required.

An audit trail documents the logic of the process that researchers follow to arrive at their final conclusions (Guba, 1981). Also, changing insights and "instrumentality" of the researcher during the research study can be addressed by establishing audit trails. The researcher created an audit trail through journal keeping. For example, journal notations documented and explained decisions to alter the wording of interview questions and the addition of specific probes. Additionally, the researcher documented emerging insights during the data collection and analysis phases to ensure the dependability of the findings.

Competent external individuals familiar with qualitative research conducted audit trails. The researcher used both fellow doctoral students and University of Alberta faculty to review the procedures and practices used in the study. This task was made less onerous by the use of computer-aided qualitative data software.

3.10.4. Confirmability

The results of a study are considered confirmable if "data exist in support of every interpretation and…the interpretations have been made in ways consistent with the available data" (Guba, 1981). Therefore, confirmability is established when the data clearly support the researcher's conclusions. The technique for establishing confirmability is the confirmability audit, through which an external researcher confirms that the results can be traced to the data (Guba, 1981).

The researcher developed a confirmability audit trail by using interview transcripts, a journal, and a computerized database described earlier in the thesis. Prior to beginning data collection, the researcher documented her biases and expected findings so that an external auditor could determine whether the biases had shaped the study's conclusions. When documenting emerging insights in her journal, the researcher referred to the specific comments in the interview transcripts that led to the idea. An external auditor should be able to examine the researcher's journal, refer back to the transcripts of the interviews, and determine whether the study's conclusions are well-grounded.

3.11. Assumptions

Through examining beliefs and values that are deeply held by participants and program staff, it is assumed that an understanding of their reality can be shared. As Greenfield (1993) stated, "no one can experience another's experience, but we may come to understand it" (p. 66). A number of key assumptions underpinned this study:

1. That participants reported their beliefs and understandings about the questions being asked. Interviewees answered questions to the best of their ability and were not embarrassed or threatened to express concerns about the program;

2. That reality is socially constructed and complex and is best understood within the context of the research participants' lives. Therefore, a qualitative research design using semi-structured interviews and participant observations was used;

3. That participant women, program staff, community partners, and key representatives of the broader community were uniquely qualified to provide insights into the functioning of HSMM.

A researcher's personal beliefs and experience also inform the qualitative research process. If not made explicit, they can unduly influence and bias the research process. The researcher made explicit her beliefs and experience related to prenatal health promotion:

- A socio-environmental approach to prenatal health promotion is essential in working with marginalized individuals and their families;
- The role of the peer outreach worker, and their practices of "cultural brokerage" (Jezewski, 1995, p. 21) with marginalized women and their families, is critical to the success of HSMM;
- Dietitians of Canada (sponsor of HSMM) should assume a primary role in providing the leadership and support that is necessary to re-orient dietitian services from a hospital-based to a community-based setting;
- HSMM should continue to involve staff, partners and participants in actively sharing lessons learned in Canada, and abroad. The program has captured the attention of people around the world who are interested in knowing more about this innovative, practical and collaborative approach to prenatal health promotion. Dietitians of Canada should support these efforts and use its communication channels nationally and internationally to draw attention to the remarkable success achieved to date in reaching and connecting with the target audience.

3.12. Delimitations

This study involved participants from two, out of eight, HSMM sites. Program staff associated with the two sites were observed and interviewed by the researcher. Additional program staff (i.e., dietitians, public health nurses and peer outreach workers associated with the other six HSMM sites) were identified as key informants through snowball sampling, and interviewed by the researcher. Several of these individuals were members of the HSMM Steering Committee and had considerable expertise and influence in community nutrition and prenatal health promotion.

The study focused on the prenatal component of HSMM and did not include the recently implemented "Baby Steps" postnatal nutrition and nurturing program targeting mothers and their infants up to one year of age.

3.13. Limitations

The research results are limited in generalizability as a result of the delimitation described above. The delimitation was a strength of this case study in that it allowed a more in-depth investigation and understanding of this sub-group. A possible limitation of the research was the practical and very real constraints that participants faced--lack of child-care and/or lack of transportation to HSMM sites. Although every effort was made to overcome these barriers, it was possible that there were other underlying reasons for women not participating including feelings of vulnerability, inexperience with focus groups, and distrust of the process. The sample selection criteria involved women and team members who were participating in HSMM, at the two sites on an ongoing basis. A limitation of this study was that women/teens who had "dropped-out" of the program, or team members who had been re-assigned, were not interviewed.

Additionally, the research design and timelines reflected the fact that the researcher lived in Edmonton and travelled to Winnipeg, MB on four or five occasions over a six- to twelve-month period. To contain costs, the intensive data collection process took full advantage of the researcher's time in Winnipeg.

3.14. Ethical Considerations

Ethical considerations in research involve concerns about participants' privacy, consent, respect and safety (Glesne & Peshkin, 1992). Ethical approval for this research study was received from the University of Alberta's Faculty of Agriculture, Forestry and Home Economics Review Committee and the Winnipeg Community Long Term Care Authority (WCA) Research Review Committee. All participants in the study signed an informed consent form indicating that they understood the nature of their participation in the study (Appendices: D, E, F, I, K). This study maintained ethical standards by ensuring that participation in the study was voluntary and that participants clearly understood that they could withdraw from the study at any time, without penalty. Data collected from participants was considered confidential. The typist engaged in transcribing the audiotapes of the interviews was reminded of the confidential nature of the information. Names of all study participants and the names/locations of the two site locations were changed for the reporting of the data. Only the code names were used in the thesis and related presentations and publications. Member checks were conducted to ensure that participants have final approval over data collected (Appendix G). In reporting the findings, the researcher followed the recommendation of Locke et al. (1987) that whenever there is "a choice between using material that is valuable to the study but that make the subject vulnerable, the interest of the subject must be selected over that of the investigation" (p. 95).

In addition to respecting confidentiality, the researcher strived to ensure reciprocity in her relationship with participants while conducting fieldwork, by fully participating in the social and community-based activities associated with HSMM.

3.15. Reflections on Methodology

The research methodology chosen by researchers says something about their views on what qualifies as valuable knowledge; it also reveals the researchers' perspectives on the nature of reality (Glesne & Peshkin, 1992). The choice of a qualitative approach to research, supported by the interpretivist paradigm, indicated that the researcher in this case study on HSMM saw reality as socially constructed, complex, and ever-changing.

Since qualitative researchers deal with multiple realities, I envisioned my task as coming to understand, and to interpret, how the study participants constructed their social worlds in the setting of HSMM. In order to make the interpretations, I had to gain access to the various perspectives of participants. Thus, this case study focused on in-depth, long-term interactions with relevant individuals "attached" to two HSMM sites. In conducting the research on HSMM, I avoided simplifying social phenomena. Instead, I explored the full range of behaviours to understand more fully the resultant and complex interactions.

To do justice to the complexity, I immersed myself in the setting of HSMM, and in the lives of others, using multiple means to gather the data. In writing this thesis, my primary goal was to make the researched phenomena accessible, tangible, and imaginable. I carefully considered the statement that "writing is a political act" and I reflected on the intended and unintended consequences of the thesis (Glesne & Peshkin, 1992, p. 171). Given that my first responsibility was to the research respondents, I repeatedly asked myself whether my choice of words and/or interpretations would result in judgements rather than descriptions of a program and its people. Nagel, a biographer, provided sound advice: "Writing about another person's life is an awesome task, so one must proceed with a gentleness born from knowing that the subject and the author share the frailties of human mortality" (Nagel, 1988, 115).

In a conscious effort to portray the humanness of the research participants, I strove to let the study participants tells their own stories. Thus, some of the quotations in Chapter 4-10 are lengthy, because shortening them would have significantly altered their meaning and/or lost some richness of the participant's perspectives. A few of the quotations have awkward syntax but their wording has not been changed.

Finally, I chose not to conclude the thesis with a list of program recommendations, specific to HSMM. I struggled with this decision. Health promotion is an applied field of study; should I not be prescriptive? I considered the writing of Glesne & Peshkin (1992) and agreed with the conclusion: "Useful outcomes do not always take the form of prescriptions" (p. 171). I reminded myself of the original purpose of the study design--to understand and describe HSMM, in context and holistically. To prescribe, although perhaps of interest to some readers, would have artificially constricted the study that was designed with other purposes in mind. Thus, my decision was to focus on the matter of prescriptions at another time, using an alternate approach. To address prescriptions when they were not integral to the research design would detract from my writing the story on HSMM.

CHAPTER 4

HSMM'S "KITCHEN TABLE" APPROACH

4.1. Introduction

As HSMM's "Kitchen Table" approach evolved between 1995 and 2000, program staff attempted to describe the defining characteristics of the approach. HSMM team members recently suggested that they used food and nutrition as a "springboard to build access, skills, confidence and social support" of participant women (HSMM, 2000, p. 20). Alternatively, the approach has been described as a method of "facing food challenges with participant women" (HSMM, 1998, p. 1). The title of the approach reflects the age-old and universal idea that the "kitchen table" is a starting point for great conversation. In response to a question asking "What can be done if a neighbourhood facility doesn't have a big enough kitchen?," staff replied, "Create one by using tables in a room." According to HSMM team members, an "easy" or relaxed style is critical to establishing camaraderie and comfort with participant women.

In Figure 4.1, HSMM's "Kitchen Table" approach is broken down into its constituent parts to visually depict the key ingredients of the approach. The researcher deliberately chose a flower to visually represent HSMM's "Kitchen Table" approach in Figure 4.1. The five-petal flower serves to introduce the gardening analogy used in Chapter 7 to describe the community organization process in HSMM. The gardening analogy also appears in Chapter 8 dealing with coalition building and advocacy in HSMM. In Figure 4.1, each petal of the flower symbolizes an important element of the "Kitchen Table" approach, as identified by the case study research findings. These include: food, milk/juice coupons, and prenatal vitamin/mineral supplements; outreach services; needs-based information; childcare program; and bus tickets/transportation to the drop-in sessions on an as-needed basis. The centre of the flower represents the actions of HSMM's interdisciplinary teams, the focus of Chapter 9.

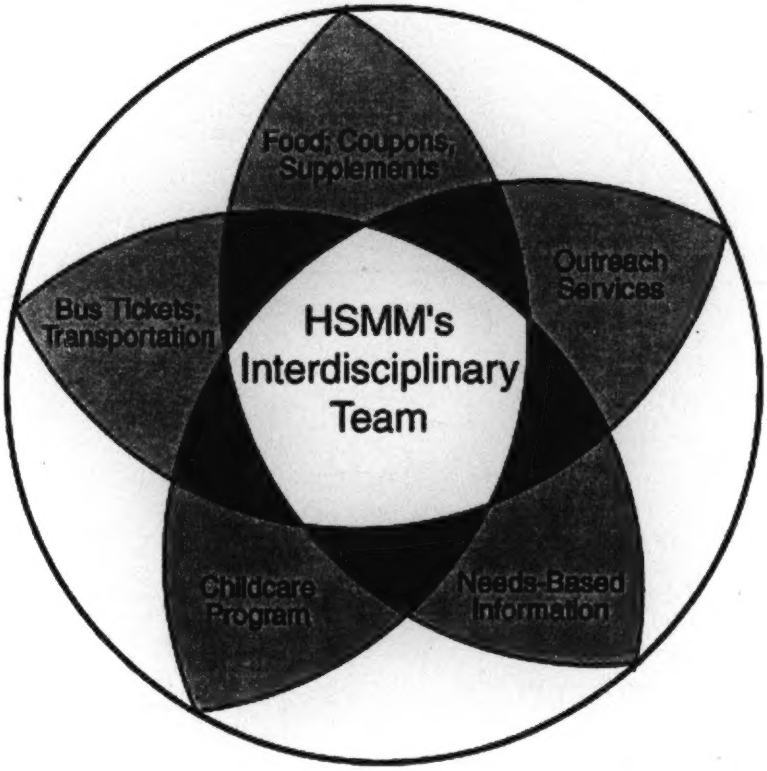

Food; Coupons, Supplements
Outreach Services
Bus Tickets; Transportation
HSMM's Interdisciplinary Team
Childcare Program
Needs-Based Information

Figure 4.1. HSMM's "Kitchen Table" approach

Chapter 4 describes how HSMM's "Kitchen Table" approach serves as a springboard to building the capacities and strengthening the support systems of participant women. The content pertaining to HSMM's "Kitchen Table" approach is divided into two sections. The focus of Section 1 is on the experiences of HSMM team members who were attached to two HSMM sites--The Evergreen Community Centre and the Willow Community Centre. Field notes, based on the researcher's observations of drop-in sessions at both sites, have been included to provide context and insight into the functioning of the program. In Chapter 4, emphasis is placed on describing the small group development roles of the peer outreach workers at the drop-in sessions. (Labonte, 1994) The peer outreach workers' "cultural brokerage" (Jezewski, 1995, p. 20) roles in

HSMM are described in detail in Chapter 6. Historical documents and artifacts describing the "Kitchen Table" approach have been included where appropriate.

Section 2 summarizes the theoretical constructs pertaining to the findings presented in Chapter 4. A model entitled "The Empowerment Holosphere in HSMM" (Figure 4.2) is introduced and described as the organizing framework for the case study research. The model depicted in Figure 4.2 serves to reflect the significance of HSMM's "Kitchen Table" approach to all aspects of program operations. The chapter summary highlights the major research findings related to HSMM's "Kitchen Table" approach and links the findings to the theoretical constructs discussed in Section 2.

Table 4.1 lists the pseudonyms used in this study including interviewees' names, context of interviews, positions, employers, affiliations to HSMM, and the approximate length of exposures to the prenatal nutrition program.

4.2. Section 1–The Context of the "Kitchen Table" Approach

To fully appreciate the context of HSMM's "Kitchen Table" approach it is important to reflect on the meaning of food in contemporary society. In this regard, Visser (1986) studied the "history and mythology, allure and obsessions, perils and taboos" of an ordinary meal. She concluded that although food is "everyday," it is never just something to eat. In the following quote, Visser described the relationship of food to civilization, past and present:

> Food is something to find or hunt or cultivate first of all; for most of human history we have spent a much longer portion of our lives worrying about food, and plotting, working, and fighting to obtain it, than we have in any other pursuit. As soon as we can count on a food supply (and so take food for granted), and not a moment sooner, we start to civilize ourselves. Civilization entails shaping, regulating, constraining and dramatizing ourselves; we echo the preferences and principles of our culture in the way we treat our food . . . . Food--what is chosen from the possibilities available, how it is presented, how it is eaten, with whom and when, and how much time is allotted to cooking and eating it--is one of the means by which a society creates itself and acts out its aims and fantasies. Changing (or unchanging) food choices and presentations are part of each society's tradition and character. Food shapes us and expresses us even more than our furniture or houses or utensils do. (p. 12)

Table 4.1

Pseudonyms, Context of Interview, Position, Affiliation, and Approximate Exposure to HSMM

Pseudonym	Context of interview	Position	Affiliation	Length of exposure to HSMM
Sarah		Manager	HSMM	5 years
Beth	Core Staff: Evergreen Site	Dietitian/co-ordinator	HSMM	5 years
Alice	Core Staff: Evergreen Site	Peer outreach worker	HSMM	5 years
Diane	Core Staff: Willow Site	Peer outreach worker	HSMM	5 years
Paula	Core Staff	Peer outreach worker	HSMM	5 years
Louise	Contract Staff	Admin. support	HSMM	4 years
Jane	Partner: Evergreen Site	Nurse educator	Family Health Centre**	5 years
Anna*	Partner: Willow Site	Public health nurse	City of Winnipeg	5 years
Sharon	Partner: Evergreen Site	Public health nurse	City of Winnipeg	5 years
Brenda*	Partner: Willow Site	Public health nurse	City of Winnipeg	5 years
Judy	Partner: Willow Site	Community dietitian	Inner-city Health Centre**	5 years
Alison	Key Informant	Nurse manager	City of Winnipeg	5 years
Nan	Key Informant	Dietitian	HSMM Ex-staff	5 years
Victoria/Susan	Key Informant	Dietitian/home economist	HSMM Sponsor/Steering Committee	5 years
Kathleen	Key Informant	Nurse manager	The Wellness Centre**	5 years
Denise	Key Informant	Manager	CPNP National Office	5 years
Dorothy	Key Informant	Foods/nutrition student volunteer	University of Manitoba	2 years
Mary	Key Informant	Social worker	Community Agency	5 years
Nora	Key Informant	Community dietitian	Health Canada	2 years
Ralph	Key Informant	Manager (Recreation)	City of Winnipeg	2 years
Mr. Fred Holt	Key Informant	Government official	Province of Manitoba	3 years

Note: * Position on the HSMM team was shared between two individuals.

** Pseudonym was used for the name of the Community Health Centre.

Visser's concept of healthy food as both a social and political issue is consistent with that of Wilkinson and Marmot (1998). They described food as a "social determinant of health" and maintained that access to good, affordable food made more difference to what people ate than did health education. Wilkinson and Marmot described a social gradient in diet quality that contributes to health inequalities. The main dietary difference between social classes is the source of nutrients--low-income individuals substitute cheaper processed foods for fresh food. When describing policy implications pertaining to food, Wilkinson and Marmot argued for "the availability of high-quality, fresh food to all, regardless of their circumstances" and very importantly, "a stronger food culture for health, fostering people's knowledge of food and nutrition, cooking skills and the social value of preparing and eating food together" (p. 25).

In 1996, global representatives attending the World Food Summit agreed that "food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to met their dietary needs and food preferences for an active and healthy life" (Agriculture and Agri-Food Canada, 1998, p. 5). Food insecurity is an escalating concern in Canada. A national study conducted by The Canadian Association of Food Banks indicated that 726,900 people used a food bank in March 2000, up more than 92% from the figure reported during the same month in 1989 (Edmonton Journal, October 17, 2000, p. 12). Approximately 40% of the food recipients were under the age of 18, an 85% increase over 1989 survey figures. Also, for the first time, Canadian medical researchers (McIntyre et al., 2000) have documented the magnitude of child hunger in Canada, estimating that it affects 1.2% of families with children under age 11, that is 57,000 families. While HSMM has not attempted to capture detailed food security data from participants, more than 75% of HSMM mothers indicated that "it was hard to get enough food" (Healthy Start for Mom & Me, 1999b).

4.3. Isolation as a Social Determinant of Health

Wilkinson and Marmot (1998) concluded that friendships, good social relations, and strong supportive networks improved health at home, at work, and in the community (p. 20). They stated that "belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health" (p. 21). Individuals who are socially isolated and/or excluded are more likely to experience poor health, increased rates of depression, a greater risk of pregnancy complications, and higher levels of disability resulting from chronic diseases. According to Wilkinson and Marmot, immigrants/refugees, ethnic minority groups, and the disabled are particularly vulnerable to social exclusion.

HSMM staff and key informants indicated that they had not fully appreciated the extent of social isolation experienced by marginalized individuals living in the communities served by the program. Sarah, the program manager, explained:

> *We knew that women were isolated, but I don't think that we had a full understanding of what that really meant, and I think we've been constantly surprised by the depth of what isolation means. The isolation that middle-class people experience in a city is one thing; those people have resources of other sorts. They can hop into a car and go places, meet with friends, or do things. When you don't have other resources, or the family that you do have is more of a liability than a support, the depth of the isolation is phenomenal. So, that one of the startling things is when we hear women say, 'I love coming to Healthy Start and meeting other women,' or 'I've never been in a program before--this is the only thing I ever come to,' or 'I've never experienced people who were this nice to me.'*

In the above quotation, underlined words reflect emphasis on the part of the respondent. Sarah hypothesized that when marginalized women initially showed up at a HSMM drop-in session, their readiness to learn, or their ability to absorb new information, was "different," as a result of their life experiences. The second quotation emphasizes how important it is to create an atmosphere of comfort and personal safety at the drop-in sessions, in order for participant women to learn. In creating a safe and nurturing environment, peer outreach workers were contributing to small group development (Labonte, 1994). Sarah suggested that the "semi-organized chaos" at a drop-in session could sometimes catch external observers off-guard. She challenged outsiders to look for the planning, incredible attention-to-detail, and constant attention to the needs of participant women underlying the diverse range of activities at the drop-in session:

> *They learn things, but the way they learn is different. These moms learn best by feeling comfortable, and by being treated as if they had something to say. The one that really got to us was when a woman said: 'You treat me like I already know something.' A lot of women have forgotten they have anything to say, that they*

> *know anything, that they have anything to offer anybody. And I think when they start feeling the best is when the group moves to a place where they're actually sharing amongst each other in a really easy way, as opposed to a contrived way.*
>
> *We put a lot of stock in creating a comfortable environment, but every now and again, you lose track of how important it is. Having chair cushions that aren't too hard, posters on the wall, table cloths . . . and with it seeming organized, but not too organized. There are a lot of people who might see it* [the HSMM drop-in] *as semi-organized chaos. Yet, I don't think it is. I think there's a thoughtfulness to it, and I credit all the team members, and I think that it's one of those things that takes time to learn. It's nearly unspoken; it's not quite as conscious any more.*

Mary, a key informant, also spoke at length about the powerful effect that social isolation has on the lives of participant women and she revealed considerable insight into the contributing factors. Mary downplayed physical safety concerns, feeling that alcohol and drug issues were perhaps more significant for many families, both in the short- and long-term. As a social worker, with years of experience in inner-city communities, Mary stressed that she was not casting negative stereotypes. Rather, she was describing her experience in working with socially isolated women and teens and the difficulties that many of them had in establishing trusting relationships. The following quotations support the findings of Wilkinson and Marmot (1998) that the isolation and/or social exclusion faced by HSMM participant women are indeed social determinants of health:

> *Isolation . . . it's just such a huge issue. I'm sitting here trying to think how to break it down, because there are many, many aspects that contribute to the isolation of these women. The isolation that I see comes from families that have lost their ability to gather together with friends in a healthy way. A lot of the families that we see have been ravaged by the effects of alcohol and drug abuse. Meaning, that they come from families where maybe the parents were absentee parents because of alcohol or drug use, so they've lost the ability to cook meals that are nutritious for their children. Their focus has somehow been--it's just been defused from family and healthy friendship relationships. The children grow up in neighbourhoods--the safety comes into this--that aren't safe, so that their peer relationships are often destructive. I know I sound like I'm being stereotypical--I'm really not.*
>
> *I'm trying to get at what I've seen both from visiting in communities and what I seeat the drop-ins. There is a lack of trust, a huge lack of trust, which comes from their* [the participant woman/teen's] *experiences growing up. They haven't had their basic trust needs met as infants, as children, and now they're parents and there's just huge issues of trust. To allow someone to take care of their precious child is just an act of trust that many of them can't do. They can't*

> *allow their child to go to day care. This comes up all the time, because they're so afraid that somebody will hurt their children. Because that is what they have experienced their whole lives. The mothers have experienced this and they're trying to make it different for their children.*

Mary concluded by commenting on HSMM's unique "Kitchen Table" approach to breaking down barriers between team members and participant women. She emphasized that it was not uncommon for HSMM mothers to arrive at the drop-in feeling scared, suspicious, and *"prickly"*:

> *With friendships, in many of their experiences, they get 'ripped off' by friends, so they don't trust their friends. It's not a healthy environment, so it doesn't promote healthy family values--and I hate that term* [laughs]*--but healthy relationships within families. So, they're suddenly brought--very frightened, very suspicious, sometimes quite prickly because they are scared of us at first--into an environment where people are laughing, where they get really tasteful food, and they're respectfully shown ways to do it* [prepare food]. *So, the atmosphere that's created at Healthy Start is special; it's so unique and special. It breaks down the barriers between the professional and the participant and that's very, very important.*

Jane's comments on HSMM's "Kitchen Table" approach emphasized the issue of safety and, like Sarah, she reflected on the fact that participating in a group, and speaking infront of others, was a new experience for many of the participant women:

> *For many of the moms there is a real lack of services and places where they can be safe. This is oftentimes the first experience they've had of being in a room with other women where it feels safe; where everyone, for the most part, is on equal footing, and where they can speak somewhat openly. So, I think for many of these women it has been the first opportunity where they feel that they have something to contribute.*

In summary, the team members' growing appreciation of the social isolation of participant women, and the significance of a safe physical environment at the drop-in sessions, were key considerations in the design of HSMM's "Kitchen Table" approach.

4.4. An Overview of HSMM's "Kitchen Table" Approach

Anna, a nursing member of the Willow Community Centre team felt that it was difficult to describe the "Kitchen Table" approach:

> *It's more than the coupons; it's more than the food; it's more than the sum of the different parts. Maybe, it's the summation of everything? The feeling that the women came* [to the HSMM drop-in session], *that they were there, and that they were sharing with other women.*

Over the years, HSMM staff members have tackled the difficult job of describing, in writing, HSMM's "Kitchen Table" approach. In the following article entitled "Nutrition in Action--The Kitchen Re-Visited," Sarah emphasized how the communal preparation of food, and the enticing aroma of food cooking, helped to stimulate conversation with participant women at the drop-in sessions. The strategies described by Sarah exemplify team members' efforts in the area of small group development (Labonte, 1994):

> The Healthy Start dietitian calls the approach 'the role of aroma.' She encourages everyone involved to get re-connected to food as a communal experience. Because everyone loves food--its smell, taste, and celebratory qualities--she uses this shared starting point as a place to develop common ground and conversation. It works! All the dietitians involved are enthusiastic about using their knowledge less formally and participants arrive with curiosity about what they munch on or devour that day.
>
> Every HSMM drop-in site (8, run every second week) starts with a snack, which is usually substantial and always cost-and-food-group-sensitive. Participants, encouraged to help out in preparation, are made comfortable. Ingredients become a topic: 'Have you ever eaten chick peas before?' 'How much does a can of tomatoes cost?'
>
> The conversation may meander and soon the public health nurse may be called on to show a video or discuss labor and delivery or make suggestions for a healthy, comfortable pregnancy. (ONE Bulletin, 1998, p. 6)

Mary described HSMM's "Kitchen Table" approach as "holistic" emphasizing the significance of the following "hooks" in drawing participant women to the program: offering food, milk/juice coupons, bus tickets, and free childcare. Her observation supports the findings of the Centre for Research in Social Policy, Loughborough University, UK (1999) that before individuals can become involved in decision-making and action on community-identified health issues, they often need knowledge, skills, and practical resources. Further, these participatory "hooks" must be built into the community organizing process:

> *I think it's a holistic kind of program. I think it's the food--food is major. I think it's the milk coupons--they are major as well. I think it's the bus tickets--they make the program accessible. I think because we provide childcare and we're working to make that better. I see that as a big drawing card for moms because they know that their kids are safe and that they're having fun. And, the drop-ins are a group experience, it's playful, they're learning. The mothers are focused on their pregnancies in a whole different way than before. Before, it was just a time to wait before you had the baby. Now, there's an opportunity to meet other moms, to share stories, to learn about what's going on with their bodies, to gain some confidence in themselves, to share in things.*

In the above quotation, Mary refers to the importance of HSMM providing childcare on-site in order for women to freely participate in the drop-in session without having to attend to their children's needs. Several interviewees expressed the importance of this component of the program. Sarah suggested that financial resources needed to be allocated to the provision of high-standard and reliable childcare--that relying on volunteer and/or donated services was not always satisfactory. Mary outlined recent initiatives to strengthen this critical component of the program:

> *I see another little offshoot coming up, and it's related to the babysitting. He* [manager, Evergreen Community Centre] *has offered us the use of his staff* [recreation technicians] *to provide some of the childcare--we're not calling it babysitting any more. They* [recreation technicians] *did a little bit in the summer with no supervision, and it was not great. They're teenagers, and they like movies, so they showed the kids inappropriate movies. Now that we have somebody on staff to help coordinate the childcare, she's going to be training the young people on how to deal with toddlers.*
>
> *That means we'll have adequate childcare that is consistent and stable and stimulating. We're thinking of not even calling it childcare. The new name would be the 'Children's Program,' because we would really like to offer the children the opportunity to participate in a program that is a valuable learning experience for them while their moms are participating in the drop-in sessions.*

A review of program documents and archival information indicated that HSMM staff had attempted to describe the "Kitchen Table" approach by focusing on what they had learned about "respect, support, and a woman-centred way of working with low-income pregnant women and with new mothers who live in the shadows" (Matheson & Wylie, 2000, p. 1). The theoretical constructs underpinning HSMM's "woman-centred" strategies are explicated in the feminist literature (Belenky et al., 1986). Peer outreach staff described recommended approaches to small group development (Labonte, 1994) under two headings entitled "This seems to work" and "Things that connect." Their suggestions follow:

This Seems to Work

- Name tags--first names only to protect privacy while encouraging connections between women (versus a sign-in sheet)
- Gentle easy ice-breaker activity at start, offering "pass" as an okay response because it acknowledges both shyness and women's wish to share (versus starting right in on planned topic)
- Setting of the room--couches, circles, posters, music, a room BIG ENOUGH to disappear in (versus a formal set up, or a room that is too small for the comfort of shy people)
- Anonymous way to ask questions and to give feedback (suggestion-box, "question can," pen and paper on-hand)
- Bring out what the woman knows. Ask: 'How do you manage for food at the end of the month? Or, "Do you know anyone who has breastfed?' (opens exploration and does not corner or "lock in" participant)
- Proved an opportunity for women to see or be involved in a recipe being made and talked about. Enabling women to repeat the recipe at home via $1.00 meal/ingredient bag (versus a passive approach where a woman is handed a recipe and served a snack)
- Cheese and familiar fruits and vegetables ALWAYS disappear (unfamiliar fruits need to be shown whole, cut and sampled)

Things That Connect

- See yourself as a woman, or as a person (versus seeing your self as a professional)
- Noticing the similarities in your life experiences (versus noticing the differences)
- Dressing casually and for comfort--jeans, apron etc.--versus 'dressing for success' (expensive grooming, clothes, uniform or labcoat)
- Giving people a chance to share their knowledge (versus assuming that people do not have the knowledge)
- Finding out what people seek (versus giving people what you think they need)
- Language such as 'previously unreached' (versus 'hard-to-reach'); 'isolated' (versus 'vulnerable'); 'peer support' (versus 'outreach worker')
- Videos and demos (versus overheads and pamphlets)
- Understanding and [using a] 'harm reduction' [approach] (versus judgment and 'zero tolerance')
- Talking about food (versus talking about hunger). (Marie Booth, 1998, pp. 1-2)

The above suggestion to use a "harm reduction" approach, versus a "zero tolerance" approach requires additional explanation. Nan, a former HSMM staff member, provided an insightful example of a "harm reduction approach" in her interview focusing on a participant woman's use of "crack" cocaine:

> *I remember when we had our first woman who admitted to using 'crack' during her pregnancy. That was our teething ring and we had to figure out how to deal with it. We needed to call on other community resources. 'Who knows about 'crack' in the community? Who knows what we should do? How do we pull them into our dialogue? How do we do this and still preserve our relationship with the mom? How do we deal with the Child and Family* [Services] *component of this issue? How can Healthy Start deal with this issue, maintain our integrity, and not drive people underground?'*
>
> *So, it was constantly challenging ourselves, and others, to build trust in responding to each of these issues as they came along. We were guided by our first principle, 'Mother and baby first.' There were no knee-jerk responses to ignore the mother's needs for 'the sake of the child.' Of course, we were all acutely aware of circumstances when the preservation of the child took precedence, but Healthy Start was all about continuing to support the mom and ensuring that she didn't feel abandoned or worthless.*

Another example of how program staff use a "harm reduction" approach was provided in the HSMM Bulletin (2000). In this example, a participant had arrived at a drop-in session obviously under the influence of "sniff":

> The power of gentleness and acceptance--An expectant woman came to her first Healthy Start drop-in obviously 'sniffed up.' The host facility wanted her to leave, according to their rules. Sensing the opportunity for connecting with a woman with obvious needs, our Healthy Start outreach worker suggested that she sit outside the building with the woman--and that she take her some food. With just a bowl of soup, and a moment of time, true outreach and support were demonstrated. This woman became a regular participant and never again came sniffed up.
>
> If she had just left feeling 'kicked out,' we wonder if she would have come back . . . . There are many faces to outreach and prevention work. (p. 1)

In attempting to describe the HSMM "blue jeans" and "Kitchen Table" approaches to an international audience of dietitians meeting in Scotland in July 2000, Sarah provided a concrete example of how a HSMM dietitian conveys information to a participant woman in a "hands-on" and user-friendly manner. The "sample situation" involved a distraught mother who said, *"This baby is always at my breast. It's making me crazy. I'm thinking about stopping* [breast feeding]." The dietitian provided a visual, "hands-on" response, where she used measuring cup utensils to demonstrate to the mother the relative size of the baby's stomach at one week of age (i.e., ¼ cup) and at one month of age (i.e., ½ cup). The dietitian also produced packets, or models, to approximate the amounts of milk--the woman could then see the packets and actually hold them. According to Sarah, "women really understand when information is provided in this way." She elaborated further:

> *Offering this factual information in tangible form instead of simply encouraging her* [the participant woman] *to be patient, tells her clearly that there is a reason for the baby's frequent hunger and that the baby's capacity will change soon. She is then better able to make an informed decision about whether to continue breast feeding.*
>
> *There are many other examples that we've developed or adapted from popular games. 'Pregnancy Pictionary' and 'Balderdash' are examples that allow us to give medical information to participant women in a fun way that avoids the lecture approach.*

Judy, a community dietitian and HSMM team member, concurred with Sarah that the HSMM approach was different:

> *It's really a different way of doing business than we've done in the past. It's not going in and giving a lecture about nutrition, or about healthy eating. It's about taking the opportunities that are there at the site to really talk with women and go in a direction that they want to explore, whatever it is. It may be shopping, or it may be having enough money, or it may be finding out about particular services that they need. Or, it may be in another area that would be helpful in the long-run to their families.*

The "Kitchen Table" approach recognized that persons with low income may not place a high priority on nutrition, given their day-to-day preoccupation with securing enough food for themselves and their families. Susan, a member of the HSMM Steering Committee, explained the difference in value systems that can often exist between individuals of various socioeconomic groups:

> *Nutrition is a major part of Healthy Start, even though we don't talk about nutrition per se, or use the word much. Any nutrition information comes in casually. It's more important to enable moms to have access to good foods and to give them some idea of how simple it is to prepare good foods, that they don't have to do fancy recipes and that kind of thing. That it's simple, that these foods are easily accessible, and very often they're cheaper than the other kinds of foods. This kind of message is never said to the moms in so many words--it's demonstrated through the use of food itself. For middle-class people, we think*

> *about nutrition and its importance in our lives. But, if just being able to buy food is crucial, nutrition is then something airy-fairy; it's just out there. You buy whatever food you can scrape together the money for.*

Brenda, a nursing member of the Willow Community Centre team, stated that an important premise of HSMM's "Kitchen Table" approach was the way the program connected food and health in the minds of participant women:

> *I think the program makes the connection between what the mom eats, her health, and the health of the baby. Because, a lot of times, it is not made--the connection is not made. For many of the moms, the connection between food and eating is feeling full. And they haven't yet made that connection to health. This program begins to build an awareness that makes a connection between food and growth and your health, the baby's health and everything.*

The list of "Things That Connect" (Marie Booth, 1998, pp. 1-2) suggested that describing participant women as "hard to reach" was not accurate. Further, the use of the descriptor increases barriers between professional staff and HSMM mothers. Sarah described in the HSMM Bulletin how program staff had come to realize that the commonly used descriptor was, in fact, a "label" that did not serve the participant women well. She wrote:

> A lesson in words and labels--Some of you will be familiar with the term 'hard to reach,' referring to marginalized or isolated people--as described by professionals. At first none of us questioned the term but assumed its truth, and even projected cautious numbers and attendance because of it . . .
>
> . . . Our profiles of participant women confirm that Healthy Start attracts the focus population it intends and as the attendance figures indicate, the 'hard to reach' description doesn't seem to be accurate. Now we use the term 'previously unreached.' Perhaps the label 'hard to reach' tells us more about traditional methodologies and systems. This isn't to negate the fact that there are individuals who resist involvement, but as one of our outreach staff who has 'been there, done that' said; 'If you CALL me hard to reach, I'll BE hard to reach!' (HSMM Bulletin, December 1998, p. 2)

In this article, Sarah refrained from referring to the HSMM participant women as a "target" population, using "focus" population instead. Apparently, the HSMM peer outreach workers voiced their concern that "target" had a very negative and violent connotation that made them and their peers uncomfortable (G. Wylie, personal communication, July, 2000).

4.5. The Setting of the Drop-In Sessions

This section includes detailed journal entries describing the drop-in session settings at two HSMM sites. Based on field notes taken during observation periods, the entries provide context and add insight into HSMM program functions. The content also focuses on the experiences of HSMM team members and key informants at the drop-in sessions at the Evergreen Community Centre and the Willow Community Centre sites. Their perspectives enhance the researcher's recollections and add depth and meaning to the discussion.

Journal Entry–November 2, 1999

Evergreen Community Centre Drop-in Session

As I drove down the street, I was surprised by the deteriorating condition of the single-family homes and boarding houses that surrounded the Evergreen Community Centre. At least five houses in one city block had been condemned by the City Housing Inspectors. They were boarded up, with notices posted on the front door. Another house had recent signs of extensive fire damage, and I wondered about arson, having seen so many arson-related stories in the local newspaper.

The Evergreen Community Centre stood out from the surrounding residential dwellings. The adjacent playground was full of brightly colored play structures and there were children going up and down the slide. The Centre was a modern, well-maintained brick building, with large windows, and a welcoming atmosphere. A pay phone had been installed outside the front door of the Centre, and, although it was late in the fall, remnants of flowers were visible in the planters located by the main door.

On walking into the building, I saw a series of bulletin boards, featuring notices for up-coming community events, program information, and advertisements for second-hand furniture and items of clothing. The Parks and Recreation staff members were eating their lunch in a glass-enclosed office and I asked them for directions to the kitchen. A young woman volunteered to show me the way. There I met the HSMM dietitian (Beth), a peer outreach worker (Alice), and a food preparation volunteer (Dorothy) from the university. The three of them were hard at work unpacking suitcases-on-wheels, which contained supplies for the drop-in session. They had just begun to prepare the food and were busy setting up materials. There were dressed casually, in jeans, and all wore name tags displaying their first names.

The main-floor kitchen was large, bright--white cupboards and bright blue counter tops--and it appeared to be very well equipped. A large island was in the centre of the room, plenty of cupboards and counter space, a double stainless-steel sink, refrigerator and freezer chest, microwave and a range, as well as a dishwasher. A TV and VCR were on the kitchen counter that staff occasionally used to show videos. "Stacking" chairs had been set up in a semicircle around the island and one of the large, locked cupboards was labeled "Healthy Start." Dorothy explained that the HSMM staff kept valuable supplies, including knives, locked-up to ensure that they "didn't go missing" between drop-in sessions. On a chair by the entrance to the kitchen, Alice placed a box filled with acorn squash, donated by the local food bank. Beside the box were handouts featuring Healthy Start recipe information and empty plastic bags for the mothers to use in transporting the squash.

Later on, during Beth's interview, she described the significance of physical space at the drop-in sessions. She provided an interesting example to demonstrate how moving from location to another dramatically increased the number of participant women attending the program. In the second quotation, Beth implied that the space at the Evergreen Community Centre site was ideally suited to communal food preparation:

> *We had the example at our _____ Avenue drop-in. It used to be in the suite of an apartment building, it was very small, and we had a small number of women coming, two, three, four women. Now we're over in a new location, a church, and we have quite a large room. We've really grown! It's fourteen, fifteen women now and it seems that the numbers are only limited by the space that we have.*
>
> *But, on the other hand, sometimes we have too large a space, for example, Willow Community Centre. We were worried that the big space would keep women away because it's intimidating having such a huge, large room. We've had to work our way around the physical structure and we try to make it more intimate. In contrast, I think that the Evergreen Community centre is ideal because we have full range of the facilities. The women come, they can sit around in the kitchen, or just talk, or they can help chop. There's the island right in the middle of the kitchen and it works really well. There's a stainless steel double sink, and a dishwasher too. It has all that. The island is in the middle with space around the outside so moms can sit around in chairs. When you compare the large kitchen at the Evergreen Community Centre to the smaller galley-style kitchen at the Willow Community Centre . . . at the Willow site you have to bring the food out, do the food prep outside the kitchen, and that poses challenges with*

> *kids running around. You don't want to put a pot in the middle of a table, with just a hot plate. It would be ideal if we could have the room where we meet right off the kitchen, and have the childcare right around the corner.*

After unpacking her cases, Beth went out to her car and returned with an electric frying pan that she had brought from her home, knowing that extra equipment would be necessary if attendance at the drop-in was at normal levels. She explained that the recipe for the drop-in session was "Pancakes and French Toast." She stated that at the last drop-in at the Evergreen Community Centre, the mothers had requested that they try something new--various soups and chili had been "on the agenda" the past few weeks. Beth indicated that "Pancakes and French Toast" had been tried at the other drop-in sites and that the recipes had gone over well.

Diane gave me the job of mixing the frozen orange juice. She placed a jug (4 litres) of milk on the counter, along with drinking glasses, and a large tin of "Quick." Diane prepared a plate of cheese and crackers, to go with the milk and juice. Dorothy reviewed the recipe for Pancakes with me and we started to prepare the dry ingredients. We also opened cans of peaches--the peaches were to be served with the French Toast--and we began to pre-heat the griddle. We tested the temperature by making a few pancakes and there was an inviting aroma of hot pancakes in the air.

Diane warmly greeted the mothers as they arrived and prepared name tags for them. One mother arrived with her partner, another with a new baby three weeks old. The newborn caused a lot of excitement! Diane left what she was doing, and approached a woman, coming to the drop-in for the first time. Diane had attempted to contact all of the mothers that morning to ask if they were coming. She had spoken with the new participant and had offered her a ride to the drop-in session. Because the mother lived close-by, she had turned down Diane's offer. Two of the mothers arrived with babies in strollers, and before dropping them off with the Healthy Start babysitters, the moms spent a few minutes talking together and having a glass of chocolate milk. Women who knew each other from previous drop-ins spoke softly among themselves. One or two mothers sat by themselves quietly, eating cheese and crackers, and drinking a glass of juice.

As the nursing members of the team arrived, Sharon and Jane made themselves name tags, and engaged in conversation with some of the mothers. The nurses were really excited to see the newborn and were interested in talking with the mother about her birthing experience. The kitchen was quite full by this time--12 mothers, the toddlers, and the team members. Beth casually introduced the recipe by asking, "How many of you have made pancakes, or French Toast, before?" As the conversation between Beth and the mothers went back and forth, she proceeded to mix up the batter, explaining the steps, and simplifying the process as much as possible. Rather than using expensive utensils (e.g., a wire wisk or an egg-beater), Beth used a fork to beat the egg with the liquid ingredients. She opened up a "Meal Bag" to demonstrate how the ingredients were pre-measured and packaged, and briefly reviewed the recipe with the mothers. At one point, Beth asked if any one of the mothers would like to assist in making the pancakes. No one offered, but one mother stepped up to help Dorothy open additional cans of peaches.

After approximately a half-hour in the kitchen, the group moved upstairs to the Multipurpose Room leaving Dorothy alone cooking the pancakes and placing them in the oven to keep them warm. Another 12 women, for a total of 24, were waiting in the Multipurpose Room for the drop-in to begin. The Multipurpose Room was large and bright with windows along one wall. It was carpeted with comfortable sofas and chairs arranged around a coffee table. The furniture was in good condition and gave the room a home-like atmosphere. Additional "stacking" chairs, with flowered cushions, were arranged in a semi-circle.

Along one wall, there were large display tables with a baby scale on one of them. A diaper change-station had been set up on another table, with a sign, reminding mothers and staff to wash their hands after changing the baby's diaper. A bathroom scale was on the floor, by the table. Screens had been set up at one end of the room, with chairs, in the event the mothers wanted privacy. The staff had decorated the walls using brightly colored, laminated posters of mothers and their babies. A pitcher of ice water, a jug of milk, and a tin of "Quick," with drinking glasses were on the coffee table.

Alice welcomed everyone to the drop-in, introduced the team, and made brief introductory comments explaining the program and providing mothers with a schedule for the drop-in sessions. She also mentioned the availability of milk coupons and bus tickets. Alice introduced the "icebreaker" activity, explaining that she'd like women to answer the question, "What have you heard about breastfeeding?" She emphasized that if moms choose not to participate, all they had to say was "pass." She started off by saying;

"It's always at the right temperature. You don't have to get up in the middle of the night to heat a bottle."

Several mothers "passed," but as others took their turn, team members had an opportunity to address mothers' comments and/or questions including: "I've heard if you don't do it right you can suffocate the baby," and "I've heard that it makes your breasts really, really sore." HSMM mothers with positive experiences of breast feeding shared their stories and they spoke enthusiastically about "doing it again." The team used props--a large picture book, a doll, and samples of recommended and non-recommended breast pumps--to demonstrate proper positioning of the infant, how to break the suction, and how to express breast milk. All of the team members offered simple advice and practical suggestions to the mothers who expressed interest in breast feeding. After going around the complete circle, the "ice breaker" activity was over, and Alice announced that there would be a short video on breast feeding, for whoever was interested. The large group of mothers broke up into several smaller groups and mothers engaged in one-on-one conversations with each other, or with team members.

During a later interview, Alice was asked to describe how the drop-in session "worked." She explained:

> *At my drop-ins we try to keep the first hour for teaching, and then the last hour is for socializing, getting to know each other better. I think that part really helps a lot. Where you're usually eating your snack and you're comparing stories, and talking, and kind of making connections with each other. I think that's really important, not just connecting with each other, but also connecting with team members. Being able to see a nurse and ask the questions you would like to ask at the doctor's office, but don't have time.*

Alice went on to suggest that nutrition is not always a priority of the mothers, but that it becomes increasingly important as their awareness of the issue increases. Alice maintained that the communal food preparation assists in increasing awareness:

> *Because of the information that's shared at the drop-ins, the moms are more aware of how important nutrition is because I don't think that nutrition was a big deal--people didn't think about it a whole lot. I think just preparing food right at the drop-in has helped, and the fact that a dietitian has met with each mom. I usually find when I do my assessment with the moms, and I tell them, 'The dietitian would like to meet with you and just talk about how you're eating, certain food groups you might be missing . . . ,' they're all eager to go and talk to her. I don't have to convince them to see her at all. They usually wait around and*

> *say, 'When can I talk to her?' It seems like there is always something going on--they're sick and they can't eat, or they can't stomach this or that, and there are always questions around weight gain. There's just so many issues around nutrition.*

In Diane's interview, she agreed with Alice that it was important to achieve a balance between the very hectic group time and one-on-one time at the drop-in session:

> *I find that when I'm distributing the milk coupons is the time that I have at the drop-in to find out what's happening, if the moms need extra help in certain areas, or whatever. So, at that time I can sort of gauge if she needs a home visit and we can book it at that time.*

Reflecting on Diane's comments, and Alice's earlier comments, I recalled Sarah's description of the drop-in as "semi-organized chaos." There was so much going on, that to the untrained observer, it might look very unorganized and chaotic. Because I knew what to look for, I was amazed at how unobtrusively team members carried out their various roles. Several of the participant women approached the public health nurse (Sharon) at the baby scales, and asked that their babies be weighed. I observed the dietitian engaged in one-on-one discussions with mothers and I saw her recording information on an assessment form. Alice was visiting with each mother individually, completing paper-work, and distributing milk coupons and bus tickets. In retrospect, the "scene" reminded me of a well rehearsed and choreographed play where the actors, being very familiar with their roles, as well as the roles of their peers, seemed to intuitively know who was doing what, with whom, and where the interaction was taking place on the busy set.

Standing next to the baby scales, I heard Sharon speaking to a couple about a baby who had lost a little weight and did not appear to be nursing well. Additionally, she pointed out to the parents that the baby had a bad "thrush" infection in his mouth. After discussing the situation with the parents, Sharon used a wall-mounted phone in the Multipurpose Room to contact a pediatrician's office, and she made an appointment for the baby to be seen by the doctor the following afternoon. She sat down with the couple and drew them a map to make sure that they knew the location of the doctor's office, not far from the drop-in session.

At a later point, the researcher discussed the operation of the drop-in sessions with Alice and Diane. The topic of partners or husbands attending the sessions was raised. Alice described how participant women were encouraged to bring their partner/husband, or a friend, to the drop-in session:

> *For the most part, the moms come to the drop-ins by themselves. But, we do let them know when we phone that they can bring someone. I definitely tell them, 'You can bring anybody. Bring your mom, your boyfriend, or a friend.' And usually they like to hear that and then they will bring a friend the first time, and then usually come back by themselves. I think it's kind of awkward, that first time, for them* [partner/husband] *to walk into this room full of pregnant women. But, once they do it the first time, it seems like they usually come back.*

Alice also provided background information on her role in transporting new HSMM participants to the drop-in session. Her comments suggested that she saw the transportation offer to new participants as an important "hook," and she explained that the vast majority of mothers are comfortable with taking the bus home:

> *I find the referrals sort of come in waves. For a while, there'll be none, and then all of a sudden there'll be a whole bunch, and I'll do lots of driving. I usually give the new moms a ride to the drop-in and encourage them to take the bus home. So, on our way to the drop-in, I kind of show her the bus stop and the landmarks so that can find their way home. And then when I'm talking to the moms on the phone, I just tell them, 'I'll give you bus fare to go home.' And, I've very rarely had a mom say that she couldn't take the bus home by herself.*

In response to a question asking Alice whether participant women connected with each other between the bi-weekly drop-in sessions, she replied that phone contact was not uncommon:

> *Pretty much every single time when I ask moms if they have met a friend at the drop-in, they say 'yes.' I've had a couple of moms say 'no' that they didn't really make friends--they just sort of made acquaintances. They know them to say 'hi' kind of thing. And, I find at my drop-ins that there is a lot of phone number sharing and just phoning each other to say, 'Are you coming to the drop-in?' We've wondered whether the moms see each other outside of the drop-in, or if they just phone each other. I know that they're phoning each other, but I'm not sure if they visit each other. I don't think that they do because a lot of the moms coming to the drop-in live in different areas, and they're sometimes far apart.*

When it was time to serve the snack, Alice and Dorothy brought the food wagon upstairs using a small stainless steel cart. An elevator between the first and second floors of the Centre facilitated the transportation of food from the kitchen to the Multipurpose Room. Dorothy made a few comments about the pancakes, emphasizing how economical it was to make them "from scratch" and how the addition of a serving of canned peaches, and a glass of milk, contributed three food groups to the meal. Dorothy referred to the Meal Bags on the side table, letting mothers know they were available for a dollar.

The snack was attractively served using place mats, serving utensils, and china plates. As the mothers and team members ate, Beth checked to see if there were anonymous questions in the HSMM "question can." She found a question written on a folded piece of paper, and with the assistance of a nurse, she discussed the answer with the large group. The question asked, "Why can't we get milk coupons after we have the baby?" Beth asked the mothers if they wanted to enter their names for a draw. A "baby layette" was the major prize, however there were also smaller prizes including a juice pitcher, measuring cups, and a cookbook. The young mother who won the draw for the "layette" very excitedly opened the bag and was obviously taken back by the lovely, and very practical assortment of baby "things" including a quilt, baby blanket, plenty of diapers, new sweater, hat and booties, baby toys, and a gift for the mother.

When all of the pancakes and French Toast were gone, the women started putting on their jackets and saying good-bye to each other. Those with toddlers went off to pick up their children. There was no formal conclusion to the drop-in session other than team members saying good-bye and "I'll see you next time." Once the mothers left, all of the team members began the clean-up operation which involved taking the dishes downstairs, washing up, and returning both the kitchen and the Multipurpose Room to their original condition.

As soon as the clean-up was completed, the team members sat down and began the de-briefing session. Led by the peer outreach worker, the session provided an opportunity to discuss what had worked well, and what could have worked better. The team also developed a plan for the next drop-in session. Team members shared concerns with respect to individual participants, and in several cases, Alice agreed to do a follow-up home visit. An issue was raised with respect to one or two women dominating the conversation and the team discussed strategies to handle the issue at future drop-in sessions. Shortly after four o'clock, HSMM team members left the Evergreen

Community Centre and headed back to their offices to return supplies, check voice-mail messages, and hopefully start to wind down at the end of a very busy day.

Journal Entry–November 4, 1999

Willow Community Centre Drop-in Session

The Willow Community Centre was located in a large City-owned building that had originally been a warehouse. The HSMM drop-in took place in the gymnasium located at one end of the building. As I entered the gymnasium, I met Alice busy setting up tables and chairs, opening windows, and readying the room for the drop-in session. An HSMM mother and a food preparation student volunteer (Jean) were in the kitchen, located next to the gymnasium. Jean was browning ground beef and the aroma permeated the room. Alice, concerned that the smell may be difficult for some of the pregnant women, was trying to air out the room prior to the mothers' arrival. Sandie was preparing platters of raw vegetables with a yogurt dip and I offered to give her a hand. The HSMM staff were casually dressed and all were wearing name tags displaying their first names.

My initial impression of the Willow Community Centre kitchen was that it appeared small and cramped. Two people were a "tight fit" in the kitchen, and three people were definitely a challenge in the confining space. The kitchen was a "galley" design with very limited cupboards and counter top surfaces. There was a small fridge, stove, and a double stainless steel sink, but no freezer or dishwasher. The HSMM staff were constantly trying to track down equipment and supplies as none of the cupboards locked. The stove was small and there was some concern that the oven was not working properly. There was a "pass-through" from the kitchen to the gymnasium--this simplified things somewhat for the staff. In an earlier quotation, Beth confirmed that the physical space at the Willow Community Centre site was less than ideal for communal food preparation.

The HSMM staff had spent a lot of time thinking about the best way to create a warm and comfortable environment at the drop-in session, given the very large and "impersonal" gymnasium space. In one corner of the room, they set up a babysitting area with a crib, mats, and a variety of toys. Directly underneath the pass-through to the kitchen, they set up a large display table and covered it with a brightly covered tablecloth. Alice placed a jug of milk, a tin of "Quick," a pitcher of ice water, and drinking glasses on the table. For a special "treat" that day, bowls of mandarin oranges were also available.

Using approximately one-third of the available space, Alice placed "stacking" chairs, with cushions, in a semi-circle arrangement. Behind the chairs, on three sides of the semi-circle, she placed large display tables, covered with cloths, to "close-in" the space and to provide a more intimate setting. She asked me to help her put laminated posters of mothers and their babies on the walls to add warmth and color to the room. Comfortable sofas and chairs, small tables, carpeting, and privacy screens were not available in the Willow Community Centre.

The other members of the HSMM team arrived. Judy, the dietitian on the team was accompanied by a dietetic intern who was there primarily to observe but also to assist as necessary. The mothers arrived individually as well as in groups. Within a 20-minute period, 22 mothers had showed up, some with new babies, and others with toddlers. Alice approached three new participants on a one-on-one basis, having connected with them by phone that morning. HSMM team members acknowledged each mother as she arrived with a comment, or in some cases, a warm smile.

Six Iranian women arrived in a group, along with an interpreter. The women were dressed casually, in fact, one woman wore blue jeans--all six women wore the traditional head covering. A Spanish-speaking mother, from South America, arrived with her toddler. She was immediately welcomed by the public health nurse who spoke Spanish. Alice had also arranged for an interpreter to assist the mother and the three of them carried on a conversation off to the side.

Alice casually welcomed all of the mothers, and guests, to the drop-in session. She provided mothers with a copy of the schedule and briefly described the HSMM program. Alice also mentioned the availability of milk coupons and bus tickets. At that point, she turned to Judy, and asked her to introduce the "ice breaker" activity. Alice assured the mothers that "passing" was acceptable.

Judy explained that the snack for the day was chili and that the staff had prepared two types--one with meat and one without. She said that she would like the mothers to answer the question, "What's your favorite meat or meat alternate?" Judy began by sharing with the group that peanut butter was her favorite meat alternate. She defined a meat alternate in very simple language, using colorful hand-made posters and a variety of props. She held up a can of chick peas as an example of a meat alternate. The Iranian women recognized the legumes by the picture on the can and volunteered that they used chick peas to make hummous. They then proceeded to share recipe ideas using meat alternates with the larger group through the interpreter.

As Judy went around the circle, women stated that "liver" or "fish" or "moose" were their favorite "meat" choices. One or two of the Aboriginal women explained that access to wild meats and fresh fish was limited, unless they returned to their home communities or reserves to visit family and friends. As women answered the question, Judy sensitively probed further, asking, "How would you cook that?" or Would you like to make that here?" As the conversation went back and forth between Judy and the mothers, one of the participants raised the issue of iron, and whether it was necessary to take an "iron pill." This question provided Judy with an opportunity to reinforce the significance of the prenatal vitamin-mineral supplements that HSMM provided to moms on an as-needed basis.

In a private interview with the researcher, Anna (a nursing member of the Willow Community Centre team) alluded to some of the challenges that the drop-in session environment presented. She spoke specifically of the difficulty in working in different languages:

> *There are challenges, because if you have women that speak a different language, you have to attend to their needs. That* [not speaking English] *is the biggest barrier there can be. So, that slows down everything, and then once you are going around, let's say in the circle, you have to stop right there and start working at a slower pace. Then, the rest of the women may end up being bored. We have tried to solve this by having small groups so that there will be a separation . . . they* [English-speaking participants] *can keep on working, meanwhile one of us will try to translate, or work with the translator, and those women who do not speak English.*

Drawing on her extensive experience in the inner-city community surrounding the Willow Community Centre site, Anna spoke frankly, and at length, of the complex dynamics between immigrant/refugee women and Aboriginal women attending the drop-in session. In the second quotation, Anna stated that one of the rewards of her work with

HSMM was seeing the two diverse groups of women establish "common ground" around pregnancy and food:

> *Working in my community for almost ten years, I've found that the immigrant/refugee women and the Aboriginal women don't always trust each other. Immigrant women have one foot in Canada, in Winnipeg, and they are already being informed that the Aboriginal people have problems, that they have addictions, and all those kinds of things, without ever hearing any background to what really happened . . . And, of course, the Native community doesn't trust these newcomers because they come with this attitude. The Aboriginal women sometimes ask, 'Who are they to come here and judge us?' I think that's kind of the feeling, the bitterness. So there all these underlying issues and I find it really challenging.*
>
> *Sometimes, I am so glad to see both groups together. There are opportunities at the drop-in for some of the ethnic women to speak English and they will engage in conversation with some of the Aboriginal women. I think it's good to see that because every little grain of sand will help in the understanding of the two communities.*
>
> *They all bring their interesting ideas about food, and because these women are always at home, because of the language barriers, because they've just arrived in Canada and there are so many cultural differences, they are always cooking. And I think the other women are learning, I hope they're learning, because one of the things that I believe is that young people growing up in the inner-city, not just Aborginals, have lost the art of cooking a nutritious meal. That's such an important skill. We* [the HSMM teams] *are always asking, 'How can we bring that back? How can we pass this on to people and help them to understand that it speaks to family, to nutrition for the family, and to traditions'. It is so meaningful, but it's so hard to do if you have never learned how. That's probably why the moms are all so interested and why they are all listening at the drop-in.*

The phenomena that Anna described of the diverse cultural groups coming together around the "kitchen table," and learning from each other, is described in greater detail in Chapter 5 focusing on the experiences of participant women in HSMM.

At the conclusion of the "ice breaker' activity, Judy introduced the recipes for the chili--one with meat and one using beans as a meat alternate. She opened a Meal Bag and demonstrated that the non-perishable ingredients were pre-measured and packaged. Five women indicated to Judy at that point that they were interested in purchasing a Meal Bag. One mother shared that she had made chili before, using the HSMM recipe in the Meal Bag, and that it had been a "big hit" with her family.

The student food preparation volunteer joined the group to let the mothers know that the chili was ready. She reviewed the recipe emphasizing how the Meal Bags simplified preparation. She asked for a volunteer to assist her with serving the chili and one or two of the mothers stepped forward. As the large group dispersed, the mothers approached team members individually with questions or they remained in small groups speaking with one another. Alice brought the new mothers over to speak one-on-one with Judy and the Dietetic Intern. I observed Judy recording information, as she spoke with the mothers individually, on a HSMM assessment form. Alice reminded the mothers about the draw for a baby "layette" and she explained how the HSMM "question can" worked. The interpreter assisted an Iranian woman in preparing a question in English, and together they put the slip of paper in the can.

After the mothers had finished eating there was chili left over. Jean and one of the mothers packaged up the leftovers in disposable cartons with lids, and the mothers were provided with plastic bags to transport the chili home. The clean-up operation began after the mothers had left. Because there was not a dishwasher on the site, cleaning-up was a time-consuming and labor-intensive process. While the work in the kitchen was underway, Alice and another team member disassembled all of the tables, stacked the chairs, and returned the gymnasium to its original condition.

The de-briefing session began at approximately 5 o'clock, and although the team appeared tired, they participated actively. I was surprised when Sarah, the HSMM program manager, arrived for the de-briefing, although the rest of the team did not appear at all surprised. I later learned that Sarah tried to attend the de-briefing sessions at all 8 HSMM sites as often as her busy schedule allowed. Judy stated that she was very pleased with the mothers' response to the "ice breaker" activity, particularly the active participation of the Iranian women. Team members discussed the importance of respecting the Iranian women's dietary laws and customs. I was impressed by their extensive knowledge of the subject. The team recognized that it would be necessary to have some type of vegetarian snack, for the Iranian women, on an ongoing basis. The discussion focused on the language barriers and the challenges in facilitating the group when working with three different languages (English, Spanish and Arabic). The team, with Sarah's input, brainstormed how to address these challenges, and decided on one or two strategies to try at the next drop-in session. Sarah reminded Alice that some of the HSMM resources on prenatal nutrition and breast feeding were available in Spanish, as well as in Arabic. Together, the team decided that the snack for the next drop-in would be Pancakes and French Toast. Judy reminded Alice that several of the mothers were diabetic and options to syrup would need to be available.

As the HSMM team members packed up their supplies and left the Willow Community Centre it was after 5:30 pm. I noticed that Sarah was the last to leave taking a few minutes to wash and put away the few remaining dishes.

4.6. Preparing Food and Eating Together

Judy, a dietitan, described the communal food preparation that took place at a HSMM drop-in centre and the important role that food played in "leveling the playing field" between team members and participant women. The preparation of food stimulated the exchange of ideas and facilitated chatting among participants:

> *We have some very creative people, people who love to cook, so I certainly don't do all the food part. I did do a lot of the preparation of food at the very beginning, but all of us had ideas for that. Food is such a wonderful place to begin, so that it was a chance for all of us to contribute something and feel really good about it, and successful, because a lot of times the food was delicious, and ideas came from all of us as to what to do and how to do it. We had sites where we would be making food along with the women. We'd have an electric frying pan set up. One of us would start out putting the food together, but then be caught up in doing something else, so someone else would go over and stir it and mixed everything up. And so it was sort of almost a communal dish that everybody took part in, and sometimes it was the moms who would come over and stir it up or check it out as it was going on.*

The following series of quotations from Paula, a HSMM peer outreach worker, suggests that it has been an ongoing challenge to actively involve the mothers in preparing food at the drop-in sessions. Paula described some of the strategies that team members used to address the issue:

> *We wish, we all wish that we were able to get the women more involved with the food preparation and learning the skills, and even in the kitchen talking during the preparation of food, because that makes for friendship and connections. Sometimes we've been successful with that, we haven't been successful all of the*

> *time because women are tired, they want to relax a little bit when they are at the drop-in. We don't want to be coercive or push them to participate in any way.*
>
> *With a new mom that comes to the drop-in, or a shyer mom, sometimes bringing her into the kitchen at least, if there's not enough room to bring the whole group in, sometimes that really helps a lot to kind of break those barriers to cooking and everything.*
>
> *And we also bring food out to the group areas when we're talking, for example, about vegetables, and then going around and giving everyone a chance to see and to taste.*

Jane concurred with Paula that HSMM's "Kitchen Table" approach was continually evolving as staff challenged each other to think of new ways to encourage the mothers' involvement in preparing food. She stated that "there was no perfect method" and that it was critically important for the team to seek new ways to make the food component an integral component of the program:

> *It's continually evolving. It's also dependent upon the dynamics of each group. Oftentimes, part of our de-briefing is, 'How can we make the food component a more integral part of the program?' There have been times when the participant women have not wanted to be in the kitchen, and so they don't. What we've done is tried to do the food preparation upstairs, which is not an ideal space. Ideally, it would be wonderful to have the kitchen connected to the multipurpose room, connected to a childcare space. It's a challenging physical space to work with. We've tried cutting the vegetables upstairs, setting up a demonstration table upstairs, taking it downstairs to cook then bringing it back up to serve.*
>
> *It's always evolving in terms of what will work best with each group. Sometimes, when everyone is upstairs, we'll ask, 'Who would like to help with the food? We'll go downstairs to the kitchen.' So, if a woman is not comfortable in the large group, it gives her an opportunity to be with just one or two women in the kitchen and that can help break down barriers and introduce her to the group in an easier way. There is really no perfect method. If it's not working, then you change direction. It's a critical piece for the women, and there's no question of giving it up.*

When discussing the participation of the HSMM mothers in the on-site food preparation, Judy shared interesting insights into some of the food-related experiences of immigrant/refugee women attending the Willow Community Centre drop-in session:

> *Many of the moms that come to the Willow Community Centre do a lot of cooking at home. And when they come to the drop-in they really seem to like to sit and chat with each other and chat with us. At times we'll have them do some preparing if we're making a dish that they're particularly good at, or if we're making a dish and we're just short of help. We have people arriving at the drop-in at different times, so it's usually the people that are there a little earlier that will*

> *come and help us in the kitchen. I'm not saying that all of the moms are skilled in the kitchen, but many of them are. I think it's culturally related--that many of the women that come from Africa or the Arab States do spend a lot of time cooking in the home and cleaning and taking care of their family, and they usually have larger families.*

In response to a question asking what techniques were effective in enhancing the mothers' participation at the drop-in session, Beth immediately spoke of the importance of the "ice breaker" activity. In the second quotation, she emphasizes how important it is not to pre-judge a participant woman--not to make any assumptions about why she chose not to participate in the food preparation:

> *I think that having the initial ice breaker really helps, even for people that don't want to participate. We definitely give everybody the option, if they don't want to participate, they don't have to. I know what it's like to be a shy person and to just dread having to introduce yourself and do some corny little icebreaker, when you just don't want to. So, by giving people the option you're making it easier for them. I noticed for a while there were women leaving the room to go to the washroom right when icebreakers were happening.*
>
> *You just keep trying and people will eventually participate. My experience in the kitchen has always been very positive, but, if you haven't food in the house, if the cupboards are always bare, if that has always been a point of contention or stress, how could being in a kitchen be a positive experience? I remember once at the Evergreen Community Centre, I gave a mom an onion to chop and I said, 'Okay, I'll be back in a second. Just kind of wait here, just chop this onion up, and I'll be back in a second.' I had to get something. When I got back, she was standing there with the knife and the onion, and it wasn't chopped. And I said, 'What's wrong?' She said, 'I don't know how to do this.' Really, you can't make any assumptions.*

Beth reflected further on the question and elaborated on her answer. The following comments speak to the importance of a good recipe with a proven track-record at the drop-in session. She also suggested that one participant, with a natural ability to "break the ice," can positively and very dramatically change the atmosphere at the drop-in session:

> *I think if you have a good recipe people will want to participate. It seems like the desserts work really well, so do the soups. It's just offering, saying, 'Would you mind chopping? I really need some help'" Or, 'Would you mind doing this part here?' I've had some really shy girls where it's worked really well because that way they don't have to talk to other people if they don't want to; they can keep themselves busy instead. Other moms just want a break and they don't want to*

> *cook because that's what they do all day, and that's fine too. Every group of moms works through it in their own way. It's kind of weird.*
>
> *If you can get one mom that's talkative and she engages other women in conversation, the whole atmosphere of the drop-in changes. Last year, we had a mom, I'll never forget her, she was supportive of the other moms, and she was very empathetic to their situations. Everyone shared stories . . . when she came to the drop-in everything changed. Before her arrival it was very quiet and really hard to get moms to speak up. It's interesting how one person can make a difference.*

Mary also spoke about the "ice breaker" activity at the drop-in sessions and she emphasized how painful it was for many participant women to participate:

> *Introduce yourself? Some of the mothers take months before they're able to introduce themselves, because they're so shy. Self-esteem? No self-esteem. And then somebody smiles at them or somebody says, 'Oh, what a beautiful baby' or 'Oh, you look really nice today. What did you do to your hair?' or some little throw-off like that, and this woman suddenly says to herself, 'Hurrah! Somebody noticed me. Somebody cares about me.' But, it's just--you* [staff] *can't be phony or insincere.*

The HSMM Bulletin (December, 1998) indicated that the program had built up a collection of popular recipes over the past few years. The following article, entitled "the Magic of Food" reflects the range of food items prepared on-site as well as the ethnic diversity of the recipes:

> Moms tell us that they appreciate the opportunity to try new, low-cost, nutritious foods as a snack at the drop-ins. What have they tried? Some examples are:
>
> - Spaghetti with Lentil Sauce
> - Easy Beef Stroganoff with Noodles
> - Chicken and Vegetables "in a flash" (using canned chicken)
> - Tomato-Bean Soup
> - Cornbread, Bannock and Oatmeal Porridge with Apple
> - Hummous (chick pea dip or spread)
> - Fruit Salad with Yogurt
> - Hot Chocolate Mix (using skim milk powder)
> - Layered Taco Bean Salad
>
> Participants make their own contributions too. One day, two Somalian women showed their drop-in peers how to make 'anjura'--a flat bread. At another site, a mom showed up early and made lasagna with home-made noodles and a cake! Food offers a comforting starting point for all kinds of topics and discussion. (HSMM Bulletin, December, 1998, p. 2)

4.7. Offering Food–Milk and Juice Coupons

Paula, a HSMM peer outreach worker, discussed the significance of the milk and juice coupons to participant women. She suggested that while the coupons are certainly important, there are other "things" that are equally as important to HSMM mothers. Paula stated that initially she was "surprised" by this fact, thinking that participant women would rank the coupons and/or the bus tickets higher in importance:

> *What do the moms like about the drop-in sessions? They tell me, 'I like the people. I like meeting other moms. It gets me out of my house' . . . I hear that one time and time again. Even in winter, our numbers continue to go up. Why are they coming when it's so cold? Women have told us, 'This is the one thing that gets me out of my house.' So, that in itself is saying that what they receive when they come to the drop-in is enough to get them out of the house at minus thirty degrees.*
>
> *The information the moms receive, that's definitely part of it, too. 'The way the information is shared, it's down-to-earth, you didn't have the big words,' I've heard that from moms many times. I think in a way it's been surprising . . . . I always thought that the answer to 'What do you like about Healthy Start?' would be 'The milk coupons' or 'The bus tickets.' But, that's rarely said. Definitely, it's 'getting out of the house, the people at Healthy Start, and the information.' Those are the three key things that I hear time and time again.*

Alice, like Paula, admitted that she initially thought that the coupons would be more important to participant women. In fact, she suggested that while the coupons are valued, the experience of participating in a group, and sharing with other women, may well be more important to HSMM mothers:

> *They* [milk and juice coupons] *are important but I kind of thought that moms would think they were more important. You know what I mean? I thought that the coupons would be the main reason for coming, but they're not, and that has surprised me. Moms have sometimes left without milk coupons, which has really surprised me, because I would think that they would wait around or at least try to get them. But, the group seemed more important to them. The coupons are very important, they do love getting them, and it's a big help for the moms. But, it's not what's bringing them to drop-ins.*

Jane acknowledged the importance of the milk coupons and emphasized that without them the dietitian would be setting up unrealistic expectations for participants:

> *Many women say how much they appreciate having the coupons. I think the value with the milk coupons is that it reinforces that nutrition message about how important milk is, and dairy products--calcium, the whole dietary piece of prenatal nutrition. So, I think it acts as a reinforcement without even looking at*

> *the economic value. Certainly, the economic value is there . . . milk isn't something that low-income people include in their grocery purchases because of the expense. So that goes without saying, but the coupons really do reinforce the healthy eating kind of message. It just gives it more validity by saying, 'We think this is so important that we've been able to arrange to get milk coupons for you.'*

Judy agreed with Jane on the value of HSMM milk and juice coupons. She added her perspective as a community dietitian:

> *It takes a lot of pressure off me as a dietitian, talking to the mothers about how important milk is, because as soon as we give milk coupons, it says to moms, 'Milk is so important for you to drink.' And it makes it so accessible for them. And so we see a lot of women, not everyone, but a lot of women automatically starting to drink milk without us having to say to them, 'You need to have it.'*

Judy also spoke of the importance of the prenatal vitamin and mineral supplements provided by HSMM, on an as-needed basis. Interestingly, Judy was the only interviewee to bring up this topic, however, there was no question in her mind as to their importance as a component of the program:

> *They* [the prenatal supplements] *are important too. Again, the more that you can put in people's hands to complete the message that you're trying to give that day, the better. So, I can give a mom a supplement and see her take it right in front of me, and that's really a benefit. And we try to raise the issue every time. We're trying to talk about iron every time and the moms are coming forward and saying, 'I'm not taking iron' or 'Should I be taking iron?' It gives us an opportunity to talk about it--about putting their supplements away where it's not within reach of small children. So, we talk about other issues that surround the iron supplement.*

In summary, the provision of food, milk and juice coupons, and prenatal vitamin/mineral supplements were key ingredients of HSMM's "Kitchen Table" approach. They were highly valued by both participant women and HSMM team members because they reduced barriers to accessing requisite protective foods and nutritional supplements. While the coupons enhanced the food security of participant women in the short-term, findings supported the conclusions of Tarasuk et al. (1998) that there is a critical need to re-examine social assistance rates to ensure that low-income families are capable of meeting their essential needs.

4.8. HSMM's Meal/Recipe Bag

In response to a question about the history of HSMM's Meal Bags, Diane provided interesting background information. Program documents, as well as interviewees, used the terms Meal Bags and Recipe Bags interchangeably:

> *I know at first we sort of started trying to find nutritious snacks that were easy to make, that were not complicated meaning that they had twenty things that you had to get together before you could make something. We really found out that women were really interested in learning how to make food. And, really being straightforward with us, saying, 'I don't know how to cook,' or, 'Can you show me how to cook this?' So, we got together and looked at some cookbooks like* The Basic Shelf *with recipes needing things that anyone would have at home. Just basic flour, sugar, no expensive ingredients. From there, we got together some recipes, tried them out, and thought, 'Would someone like this, or not?' We came up with about six recipes at that time. Then we asked volunteers to put together the Meal Bags, with the non-perishable ingredients. I think at first, we bought some of the perishable food and gave it out at the same time as we gave out the Meal Bags, if the moms decided to purchase it.*

HSMM program documents described the Meal Bags as "promoting dignity" through "choice not charity." The following article suggests that the idea to charge participant women $1.00 for the Meal Bag--additional costs were subsidized by the program--was a deliberate attempt to move away from the "handout" model of dealing with food insecurity:

> Choice not charity promotes dignity. Ready-to-cook Recipe bag ($1.00 to serve 4-6):
>
> - Pre-measured ingredients with recipe
> - Organized by paid person; compiled by volunteers
> - Increases access to healthy food
> - Reduces barrier of shopping requirement
> - Build skills
> - Reinforces learning
>
> We wanted to get away from a handout model of dealing with food security, while still acknowledging that participants need good food. For a dollar women can choose to buy a recipe bag. For her, it increases access to healthy food and new tastes; reduces barriers, enables mom to try a new recipe with ingredients supplied; reinforces learning; enables her to have something stashed for the end of the month when the money is tight. The cost is subsidized so some 'charity' remains but the ability to choose to purchase increases mom's feelings of competence. (Matheson & Wylie, 2000, p. 21)

Paula described the importance of the HSMM Meal Bags in encouraging participants to try new foods. She provided a personal example related to her use of skim milk powder as a lower-cost alternative to fluid milk:

> *Trying new foods is a big thing as well. And, I've really seen since our Meals Bags were implemented, our dedication with that has increased. We really work hard to bring the Meal Bags to the drop-in and to encourage the women to buy them. One of the dietitians spent a lot of time trying to find recipes that are fairly easy to make, taste good, introduce some new foods but at the same time use ingredients that the moms know well, and are fairly affordable. We've prepackaged all the non-perishable items--that means pre-measuring all the spices, macaroni, rice...whatever. All the Meal Bags try and include as many as food groups as possible, a minimum, I think, of three in each bag.*
>
> *We use skim milk powder all the time at the drop-in sessions and in the Meal Bags. I know even with my own cooking at home, when I was getting food from the food bank, I'd always get skim milk powder, but I never knew how to cook with it. Now, I cook with it all the time, because I've seen recipes that use it, and I have a whole bunch of recipes that call for it. So, that's another thing we've taken, skim milk powder, something that's often given out at the food bank, and we've turned it into a normal, usable item.*

When talking about the HSMM Meal Bags, Jane suggested that the participant women and the professional team members shared in common a desire to find tasty, easy-to-prepare, low-cost recipes that would be popular with family members. She maintained that the opportunity to see a recipe being prepared and to actually taste the finished product greatly increased the chances of HSMM mothers following through at home:

> *I don't think the women are different than I am. There are foods that I don't cook because I don't know how they're prepared. So, if you see someone do it or you have an opportunity to try something that you've never tried, then it breaks down that barrier. You'll be more inclined to pick it up in the store and to try it at home if it's been a positive experience for you. So, I think that the Meal Bags do increase people's knowledge of different foods and the value of different foods and differing ways of preparing foods. Certainly, quick meals, that are family friendly, make a big difference.*

When discussing the Meal Bags with Alice, she shared her thoughts on the practice of charging participant women $1.00 for them. She suggested that positive feedback from HSMM mothers at the drop-in centre motivated other women to give the Meal Bags a try:

> *Instead of giving them away to the moms, we thought it would be nice just to charge something that they could afford. So, we're putting it back into their hands instead of it being like a giveaway. We just charge a dollar--and the moms really like to buy them. They usually come back to the drop-in and tell me their favorite recipe and how their kids enjoyed it. Some Meal Bags are for making soup, and right at the drop-in, in front of everyone, they'll mention something that they did to the recipe, how good it was, and that now they make it all the time. One mom in particular, she never cooked before, and now she always wants Meal Bags at every drop-in so that she can cook, because she's seen it done.*

In summary, HSMM's Meal/Recipe Bags represented a creative, practical, sensitive, and respectful approach to improving the short-term food security of participant women and their families.

4.9. Future Plans

Future plans were not discussed at great length by interviewees nor were they referenced in program documents. A possible explanation is that program staff and community partners were overwhelmed by the tremendous growth in the program since its inception. They were expending considerable resources just to keep up with present demands and were not in a position to plan for expansion of the prenatal program at this time. Three topics that were raised in interviews with program staff and team members are discussed below--Birth Planning, a Community Kitchen, and a HSMM Health Fair.

4.9.1. Birth Planning

In reviewing current issues of the HSMM newsletter and staff meeting minutes, I had a "hunch" that the topic of birth planning had been identified as an issue of increasing interest to the HSMM mothers and their partners. When interviewing Sharon, she revealed that it was not uncommon for participant women to be returning to the program with a second pregnancy:

> *I'm thinking of one particular mom--it was difficult to get her to come to the drop-in session, it was her first pregnancy and I think that she came just at the end of her pregnancy. She was a teenager, sixteen or seventeen, around there. She seemed to enjoy it and she has come back for her second pregnancy, without an invitation. She just knew that this was where she should come and she came back towards the end of her second pregnancy. So, I think it's rewarding for us to see that some women feel very comfortable and come back. Healthy Start hasn't been*

> *around long enough for people to have third pregnancies, but we certainly have had second pregnancies, people coming back.*

Mary confirmed my "hunch" and she spoke at length about HSMM's recent attempts to sensitively and respectively introduce the topic of birth planning at the drop-in sessions. She suggested that obviously the issue was more important to postpartum women than to prenatal participants:

> *It's an issue that can easily be overlooked, because there are so many other issues to look at, and I think it's the same thing on the prenatal side, where there are just* *so* *many issues around healthy pregnancies and healthy child rearing. So, what we're doing on the postnatal side is, we're going to make a huge effort to normalize birth control.*
>
> *Believe me, that's not easy. What it means is, we're going to have a 'birth control moment' at every* [postnatal] *drop-in. The public health nurse is going to pull out a birth control device, talk a little bit about it, and get the parents to talk about it in the same way that they would talk about eating an ice cream cone. That's my goal.*

In an attempt to "normalize" birth control with participant women, Mary felt that it was important to give the mothers the knowledge necessary to raise their self-esteem to the point where they could begin to take some control over their lives:

> *The reason that's my goal is not just to familiarize them with different kinds of birth control, but to start getting at the issues of self-esteem that are involved in not using birth control. People don't talk about sex, because you just don't talk about it. People don't talk about birth control, because, you know . . . There's* *so* *much misinformation, so many myths. It's sort of one of those subjects that people are afraid to bring up, so the experiment is, bring it up* [at the drop-in] *and see what happens.*

She suggested that most women, not all, responded very positively to the "birth control moments" offered at the post-partum drop-ins:

> *And what has happened, when we have brought it up, is that there is such intense interest, it's phenomenal! Our public health nurse was describing the female condom, and there was a father at the drop-in who got the giggles and couldn't stop laughing. It was just the most hilarious thing I've ever seen. It was funny.* [laughs] *It really was, honestly! We weren't being totally serious, but we were trying to make this a serious thing, so I could make a comment like, 'Yes, having this* [the female condom] *is very important for preventing sexually transmitted diseases and stuff.' Anyway, he* [public health nurse] *went through this very, very thorough description of how you use a female condom, and describing it, and he did a brilliant job! And after he finished, we were going, "Oh, God!* [laughs]*--this*

> *was something else! We were just blown away. I wish we would have it on video. And the moms asked really relevant, good questions. They were like litmus paper trying to absorb the information. But after, he* [public health nurse] *had five female condoms to give away and seven women came up for them.*

Mary was asked whether there were other ways to provide information on birth planning to participant women and their partners. She replied emphatically that pamphlets, and other forms of written information, are not effective. In the second quote she alluded to the fact that "user-friendly," reliable information on birth planning is difficult for women of all socioeconomic backgrounds to access:

> *Pamphlets are a big waste of time. Save the trees and don't do pamphlets. They just don't work. They* [participant women] *are not readers. They absorb information from experience.*
>
> *I'm* *really* *excited about this* [the 'birth control moment'] *because I think that the moms are going to absorb this information if we give them permission to speak about it* [birth control] *in the same way our society has recently given women permission to speak about childbirth.*

4.9.2. Community Kitchen

Beth expressed interest in implementing a community kitchen between the bi-weekly drop-in sessions. In her mind, this would provide an opportunity for participant women to prepare food communally with the goal of taking home four or five low-cost supper meals that could be frozen and used on an as-needed basis:

> *Sarah and I have talked about doing a community kitchen and that's something I would really like to build in. It might encourage women to participate more, and we could offer it on a different day than the Healthy Start drop-in. It would be another way to introduce new foods to women and help them develop more cooking skills. Maybe we could even use the Healthy Start offices because we have kitchen facilities at Knox United Church. That would be on a wish list of mine.*

Kathleen, a member of the HSMM Steering Committee, also expressed interest in the pursuing the idea of a community kitchen:

> *In terms of the nutrition piece, I think we're doing as much as we can during the actual drop-in, but I wonder if, in the future, we could build on the basic cooking skills and nutrition information. I assumed that everybody could sort of cook, or had a pot, or a hot plate, can opener, those kinds of things. I realized early in the process, that it's just not so. Those aren't the kind of things that you learn from reading a book or being told what to do. You almost have to do it hands-on, and if you don't get that experience as a young person, where do you get it? A lot of people have absolutely no confidence that they could ever do those kinds of things. It just feels so out of reach. So I think with a little more one-on-one, even for short periods of time, then you'd feel more confident about trying certain things. If we could somehow build on the Healthy Start experience, that would go a long way.*

4.9.3. HSMM Health Fair

Sarah, the HSMM program manager, raised an interesting idea that she hoped to follow through with in the near future. She proposed a HSMM-sponsored Health Fair which would include participant women from all eight HSMM sites getting together to acquire relevant and practical health information, socialize, enjoy good food, and hopefully engage in new and interesting experiences:

> *One of the things that I've been thinking about lately is, I don't know what you'd call it, I don't think you could call it a conference, but maybe you could call it a Healthy Start Workshop or a Healthy Start Health Fair. Some kind of event where women come together in a way that professionals do, but without feeling that they need to be like professionals, and listen to different topics, eat good food, and mix with each other. I think that would be fun and an interesting thing to do. We could build in babysitting. And, maybe go a little further than you would with a regular workshop. We could include things that are nurturing to the mom, like having a massage therapist there . . . a person who could give her a haircut, and add in a few extras to keep building on the things that matter in life, based on our economic circumstances. It's important to keep on building on the things that matter practically to participant women.*

In summary, interviewees discussed future plans tentatively. Given the ongoing challenges related to the overwhelming response of participant women to the program, and the increasing pressure on staff and community partners to meet the identified needs of the target population, future programming did not appear to be a priority.

4.10. Section 2–Theoretical Constructs

4.10.1. The Empowerment Holosphere in HSMM

An important finding highlighted in Section 1 of this chapter is that there are no "quick fixes" to addressing the food challenges of participants and that healthy eating cannot be tackled in isolation from the broader social, political, and economic environment (Travers, 1997a, 1997b; Kent, 1988). Further, programs like HSMM, must be seen as contributing to changes in short-term nutrition indicators such as participants' skills and confidence to broaden their food "repertoire," or to make healthier food choices through increased access to lower-cost, high-quality food. HSMM's "Kitchen Table" approach is not the only answer to addressing health inequities faced by participants and their families. However, research findings presented in Section 1 suggested that the components were part of a wider population-based strategy to improving health.

The "Kitchen Table" approach recognized the potential of food and nutrition as an entry point to population health. At the same time, the approach was realistic and sensitive to the everyday challenges faced by persons with low incomes. According to team members, HSMM's "Kitchen Table" approach offered a "healthy start" to improving the food security of high-risk pregnant women/teens and their families. Thus, The Empowerment Holosphere in HSMM (Figure 4.2)--the organizing framework for the case study research--reflects the significance of the "Kitchen Table" approach to all aspects of program operations.

The model depicted in Figure 4.2 serves to illustrate HSMM's approach to empowerment education. In designing the model, The Empowerment Holosphere (Labonte, 1994) was modified to reflect case study research findings. In Figure 4.2, the "Kitchen Table" approach appears in the centre of the model and is portrayed as a five-petal flower linking the five overlapping rings of the Holosphere:

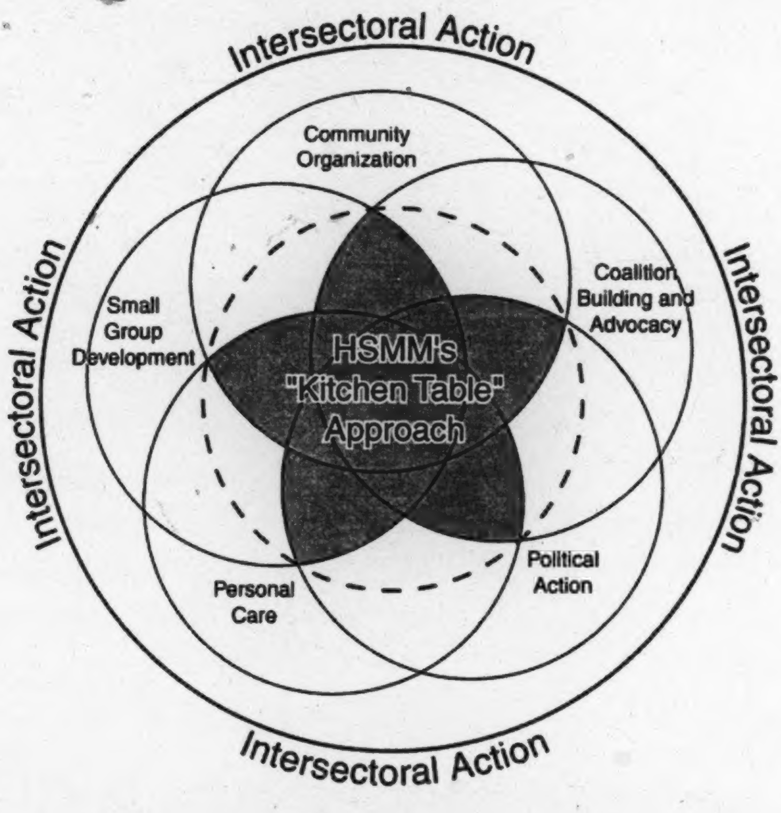

Intersectoral Action
Intersectoral Action
Intersectoral Action
Intersectoral Action
Community Organization
Coalition Building and Advocacy
Political Action
Personal Care
Small Group Development
HSMM's "Kitchen Table" Approach

Figure 4.2. The Empowerment Holosphere in HSMM.

The Empowerment Holosphere in HSMM (Figure 4.2) suggests that the design and implementation of the "Kitchen Table" approach was the initial step in the empowerment education process. The centrality and relative size of HSMM's "Kitchen Table" approach in The Empowerment Holosphere in HSMM (Figure 4.2) underscores the significance of the approach to other aspects of program operations. More specifically, research findings indicated that the "Kitchen Table" approach was primarily responsible for attracting participant women to the program and sustaining their involvement in the drop-in sessions.

HSMM can be conceived as a series of overlapping spheres or "levels" of empowerment (Figure 4.2: The Empowerment Holosphere in HSMM). The defining features of the five spheres are discussed in Chapters 5-10. The model serves to highlight the relationships between the spheres that influence the functioning of HSMM. Hence, the diagram provides a useful organizational framework for the case study research. Consistent with a primary principle of holographic design (Morgan, 1997), it is important to emphasize that HSMM's model of empowerment education (Figure 4.2) is very much a self-organizing, emergent phenomenon. Additionally, the overlapping boundaries of the five spheres are fluid and an intervention and/or strategy may not be restricted to any one sphere. For example, advocacy is a strategy that was employed by participants and practitioners in varying degrees at every "level" of the Holosphere.

While The Empowerment Holosphere in HSMM (Figure 4.2) links actions around all five spheres, no one practitioner and/or organization, possesses the resources (i.e., time, skills etc.) to work simultaneously in all five spheres. According to Labonte (1994), the Holosphere "represents an imperative for the organization [HSMM] as a totality" (p. 59). Labonte (1994) maintained that actions in all five spheres were necessary to achieve and sustain social change.

In HSMM, the key ingredients associated with "Kitchen Table" approach (Figure 4.1) facilitated interventions targeting the first "level" of The Empowerment Holosphere (i.e., sphere 1--personal care). The provision of peer support, outreach services, and the actions of the interdisciplinary team were critical in advancing to the next "level" of the Holosphere (i.e., sphere 2--small group development). Further, the research findings confirmed that the "Kitchen Table" approach linked the community organizing activities (i.e., sphere 3--community organization) to the upper "levels" of The Empowerment Holosphere (i.e., sphere 4—coalition-building and advocacy; and sphere 5--political action). Finally, the interdisciplinary practices of HSMM team members (intersectoral action), represented on the outer ring of the Holosphere in Figure 4.2, integrated all of the strategies depicted in spheres 1 through 5.

4.11. Summary

This chapter focused on how HSMM's "Kitchen Table" approach served as a springboard to improving participants' access to food, enhancing their cooking skills, increasing their confidence, and strengthening their social support networks. The drop-in sessions, and the activities related to preparing food and eating together, provided common ground for participants and program staff to work together in innovative ways. In Figure 4.2 (The Empowerment Holosphere in HSMM), the relative size and centrality of HSMM's "Kitchen Table" approach underscores its significance to all aspects of program operations. The model serves to suggest that the design and implementation of the "Kitchen Table" approach was the initial step in the empowerment education process.

Research findings suggested that there is no "magic recipe" to guarantee the success of a drop-in session or to prescribe which type of drop-in session works best in any given situation. Additionally, information gleaned through interviews with HSMM team members, and direct observation, suggested that the "semi-organized" or chaotic environment at the drop-in sessions belied the high degree of planning, attention-to-detail, and constant sensitivity to the identified needs of participants. Of particular importance was the manner in which team members unobtrusively carried out their administrative responsibilities, conducted assessments, and competed mandatory paper work, while sensitively adhering to the needs of participants--individually, as well as in the large group.

While the "flavour" of the drop-in sessions was neighbourhood-specific, factors were identified by interviewees that appeared to positively affect the outcomes. A critical factor was the need to adopt a holistic approach to healthy eating. This meant that food and nutrition issues had to be addressed from within a broad socio-environmental context, as described by Labonte (1994). Program staff and key informants identified many factors as important to the successful implementation of HSMM's "Kitchen Table" approach. A partial list of the most salient factors follows:

- Relaxed, friendly, and supportive environment at the drop-in sessions;
- Opportunity to meet, or chat with, other women and teens in similar circumstances;
- Enjoyable and useful "hands-on" activities carried out in an informal atmosphere--e.g., the "ice-breaker" conducted at the start of the drop-in session and HSMM's "question can";
- Use of trained interpreters to reduce language barriers faced by HSMM participants;

- Physical setting conducive to communal food preparation, large enough or small enough to suit the number of women in attendance, and sufficiently flexible to meet the diverse demands of the program;
- Provision of high quality, free childcare on-site, but in an area separate from the drop-in sessions;
- Free milk and juice coupons, and prenatal vitamin-mineral supplements, provided to HSMM participants on an as-needed basis;
- Nourishing snacks with the recipes and suggestions tailored to participants--HSMM Meal/Recipe Bags available, when possible, to increase the capacities of the women to make the meal at home;
- Easy-reading materials and culturally relevant videos;
- Assistance with transportation of the women to the site, e.g., provision of bus tickets and/or a ride to new participants;
- Practical draw prizes, e.g., cooking utensils, diapers, baby blanket;
- Flexible "plans" driven by the expressed needs and concerns of participant women--no formal, pre-determined agenda or outline for the drop-in session.

While interviewees focused on the factors that contributed to successful outcomes at the drop-in sessions, several issues were raised with respect to "what didn't work." These included difficulties with baby-sitting arrangements causing the mothers to be distracted; women who tended to dominate the group discussion making it difficult for shy women to participate; team members' lack of success in consistently finding a balance between providing "too much" or "too little" information at the drop-in session; ongoing staff challenges related to actively involving the mothers in food preparation; and, in situations where more than one interpreter was necessary, keeping the attention of the large group focused and background noise levels to a minimum.

CHAPTER 5

THE EXPERIENCES OF PARTICIPANT WOMEN IN HSMM

5.1. Introduction

Chapter 5 is divided into two sections. Section 1 describes the experiences of participant women in HSMM. It begins with the reflections of the researcher and the trained facilitator on the focus group interviews held at two HSMM sites--The Evergreen Community Centre and the Willow Community Centre. Two semi-structured focus group interviews were conducted to elicit participant's perceptions of their experiences in HSMM without imposing any of the researcher's views. The focus group interview at the Evergreen Community Centre site consisted of 12 participants and lasted approximately one-and-a-half hours. The focus group interview at the Willow Community Centre site included 11 participants and took slightly over one hour. While all self-selected focus group participants were "enrolled" in HSMM, there were considerable differences among participants with respect to age, race, cultural background, and length of exposure to the program. The group interviews were especially useful for generating ideas in a dynamic where participants learned from one another and developed ideas together (Creswell, 1998).

In addition to the information gleaned through the two focus group interviews, historical documents and artifacts describing the experiences of participant women in HSMM have been included where appropriate. Further, the observations and perceptions of program staff, community partners, and key informants have been used on a limited basis to enhance the research findings related to the experiences of participant women in HSMM.

Section 2 summarizes the theoretical constructs underpinning the research findings discussed in Chapter 4. A critical social science theory includes empowering strategies at the personal, interpersonal (small group), community and policy levels (Labonte, 1994). The Empowerment Holosphere in HSMM (Figure 4.2) is introduced and described in Chapter 4 as an organizing framework for the case study research.

Chapter 5 focuses on empowering strategies within the sphere of personal care (Figure 5.1: The Empowerment Holosphere in HSMM--personal care) and describes strategies within an overlapping sphere entitled small group development. The discussion pertaining to the second sphere (i.e., small group development) continues in Chapter 6. The role of powerlessness as a risk factor for disease and the concept of empowerment as a health-enhancing strategy are explored within the context of HSMM. The chapter summary highlights the major research findings related to the experiences of participant women in HSMM and links the findings to the theoretical constructs introduced in Section 2.

5.2. Section 1--Experiences of Participant Women in HSMM

5.2.1. Sphere of Personal Care

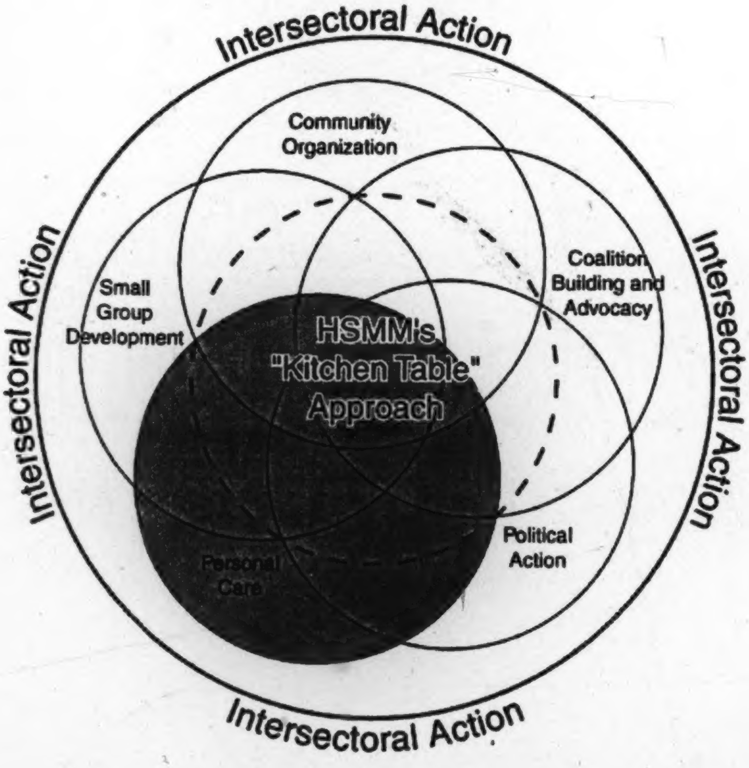

Intersectoral Action
Community Organization
Small Group Development
Coalition Building and Advocacy
HSMM's "Kitchen Table" Approach
Intersectoral Action
Intersectoral Action
Personal Care
Political Action
Intersectoral Action

Figure 5.1. The Empowerment Holosphere in HSMM (personal care).

5.2.2. Reflections on Focus Group Interviews

This section describes the process of conducting the focus group interviews at two HSMM sites. The content is based on the recollections of the trained focus group facilitator as well as on the reflections of the researcher. The researcher participated in both focus group interviews as an observer and as a recorder. The field notes taken by the researcher during the focus group interviews were later incorporated into journal entries. At the time of the interviews, the facilitator (Mary) was not directly involved with the operations of HSMM and she was not known to the majority of participants.

According to Brookfield and Preskill (1999), many differences are inherent in every group. One central purpose of group discussion is to broaden horizons and deepen understandings by taking full advantage of the diversity in participants' backgrounds, experiences, personalities, and meaning structures:

> Race, class, and culture frame how people interpret, understand, and explain others' words and actions. The fewer values, assumptions, and beliefs shared by a group of people who gather to talk, the harder it is for them to understand each other. Although differences can to some extent be overcome, they present formidable obstacles. Discussions held in the face of such differences require participants to be unusually patient and sensitive. They need to be aware of the tendency to think that views diverging significantly from one's own are by definition wrongheaded or corrupt. This tendency must be fought if honest and probing discussion is going to occur among people from different backgrounds and cultures. (p. 129)

Brookfield and Preskill (1999) maintained that "talking across differences" can be an enlightening and mutually satisfying experience, especially when participants come to the group discussion with feelings of hope and confidence in the process. Stewart et al. (1996) have stated that one principle of participatory and feminist research is that research should benefit study participants. HSMM participants indicated that the focus group interviews had been a positive experience for them. The women stated that that they found the group interviews to be both interesting and challenging. Additionally, the interview process provided a welcome outing, offered an opportunity for expression, and validated the participant women's experiences of HSMM. The facilitator and the researcher were sensitive to the possibility that the pressure to speak in a group setting may be painful for some participants. They attempted to minimize participant's anxieties by keeping the process very informal and allowing participants to "pass" or to decline comment, as necessary.

5.2.3. Willow Community Centre Focus Group--11 Participants

The process of conducting the focus group interview at the Willow Community Centre site was complicated by the fact that seven of the eleven women did not speak English. Six women participated with the assistance of an Arabic-speaking interpreter and one woman worked with a Spanish-speaking interpreter. Both professional interpreters had previously provided services to HSMM program staff. The remaining four participants in the focus group interview spoke English. Mary, an experienced facilitator, later reflected on the interesting group dynamics:

> *I do recall the atmosphere* [at the Willow Community Centre interview]. *At the beginning, it was one in which the immigrant women sat in a collection and the Aboriginal women were around the table at the other end, and there was very little communication between the two groups. I used the same process as I'd used at the Evergreen Community Centre focus group interview. I began by asking each participant for comments on the questions. And everyone did fairly well, although the immigrant women kind of consulted each other to come up with a unified answer, simply because there were language difficulties with some of the women.*
>
> *I think that the immigrant women were from Kurdistan, or northern Iraq. There were six or seven women from Iraq, and I think Iran, at that end of the table, and one woman I think from Mexico City who was Spanish-speaking. And there was an interpreter working with the Muslim women--we call them that just because it's a short form. They talked among themselves to sort of translate words that they didn't understand, and then presented an answer. So that took a bit of time.*
>
> *And I think that it kind of broke the rhythm of the focus group in the sense that at the Evergreen* [Community Centre] *group interview, each participant spoke for themselves--individually--so that you could get a kind of rhythm going. At the Willow* [Community Centre] *interview, there was a bit more chaos and there were also older children in the room. We had babysitting in the room next door, but the children were more interested in being with the moms than they were in being with the babysitter.*

The researcher's notes taken during the Willow Community Centre focus group interview captured the sentiment that the immigrant/refugee women wanted to be included in all aspects of HSMM programming--in their words, "*to be part of you guys.*" The Muslim women described the atmosphere at the drop-in session as "*kindly*" and *"friendly"* and they emphasized that the program staff made them feel *"safe"* and *"very much at home."* Mary felt that the drop-in sessions provided the immigrant/refugee women with a valued opportunity to interact with Canadian women:

> *One memory is that they* [the Muslim women] *were really concerned about having some interaction with Canadian women to foster better understanding of themselves and their traditions and their religious beliefs, which obviously are so different from other participants'. And, I also believe they were attempting to bridge that gap between Canadian and immigrant women and wishing to be better understood and to make inroads into their place in Canadian society--to find a place for themselves. At the very end of the focus group, I think that I began to ask a few questions, and the other women did as well, specific to their cultural beliefs.*
>
> *When the pizza came out, there were some questions around that. And then the Aboriginal women were a little more comfortable and a little more confident in asking questions of the Muslim women. So, once you and/or I began to ask them questions, the Native women were able to also ask a few questions of them. And it felt kind of nice; it felt like an opportunity for them to share a little bit of information.*

The Willow Community Centre focus group interview took place during Ramadan--a religious holiday for the Muslim women. In keeping with their tradition, the immigrant women explained to the group that they were fasting. On hearing this, the Aboriginal women looked a little surprised and they sensitively questioned the Muslim women as to whether they should be fasting while they were pregnant. The Iranian women replied that they were supposed to fast during Ramadan, regardless of being pregnant, but if they became lightheaded or felt weak, they were allowed to eat. The Aboriginal women explained that according to their cultural practices they were not supposed to fast while pregnant. The interaction between the participants--the Iranian women, Aboriginal women, and others in the group--was friendly and supportive. The Aboriginal women's interest in the fasting issue reflected genuine concern and curiosity on their part. The participants' questions with respect to the Muslim women's dietary practices and cultural traditions were asked in a courteous, respectful, and nonjudgmental manner.

A vegetarian snack--pizza--had been provided at the Willow Community Centre site because the researcher was aware of the Muslim women's dietary restrictions. The first indication that something was wrong came when the vegetarian women started asking detailed questions including; "Who made the pizza?" and "How was it prepared?" It was apparent that the Muslim women were concerned about the possibility of cross-contamination. One of the women questioned whether the pizza could have come into contact with meat: "Maybe an employee at the restaurant cut the pizza with an un-washed knife that had been used to slice meat?" These questions, and others, led to an interesting and dynamic group discussion on the dietary practices of the focus group participants. The conversation served to illuminate some of the challenges related to cross-cultural communal food preparation. The researcher noted that the Muslim women ate the mandarin oranges and drank the chocolate milk, however, they chose not to eat the vegetarian pizza.

As Mary continued to reflect on the focus group interview at the Willow Community Centre HSMM site, she provided some interesting insights into the experiences of the immigrant/refugee women:

> *From my subsequent knowledge of some of the Muslim women, and from some of the comments that they made, I've learned that in their culture they don't discuss things about readiness for birthing or prenatal information--it's all done within the family. So, the idea of them going out of the family to get that information is very new. They're here as a nuclear family, having left most of their extended family behind. And there is no support for parenting either, because traditionally that also is done in an extended family setting. So, they* [the Muslim women] *were looking for information at the drop-in sessions and I believe that the milk coupons were very, very important to them.*

The researcher's field notes indicated that the Muslim women gathered at one of the participant's apartments, located close to the Willow Community Centre site, and that they walked to the HSMM drop-in session in a group. When this information was shared with Mary, she commented on the importance of their social support network: *"I think that's really important. I would imagine that's extremely important for them in fostering friendships and leaving the isolation that would come with the immigrant experience."*

The above quotations reinforce the idea that comprehensive prenatal programs targeting high-risk women and teens must focus on the social, economic, and cultural environment, rather than on health behavior alone. Consistent with the ecological model for health promotion (McLeroy et al., 1988), the observations suggest that appropriate changes in the social environment will produce changes in individuals, and that support of individuals is essential for implementing environmental changes. While the health information provided at the drop-in sessions was important to the immigrant/refugee women, the opportunities to establish social networks and to begin the acculturation process were equally important. Further, the provision of practical resources and supports (e.g., milk coupons, prenatal supplements, and on-site baby-sitting) were highly valued by participant women.

5.2.4. Evergreen Community Centre Focus Group–12 Participants

Both the focus group facilitator and the researcher have vivid memories of the Evergreen Community Centre focus group interview because one of the participants showed up in active labor, explaining that her "water had broken" earlier in the day. At the time the interview started, the mother's contractions were approximately 10 minutes apart. The facilitator (Mary) and the researcher were in a quandary as to how to handle this risky, and potentially dangerous, situation. It was apparent that the participant (Katie) very much wanted to be included in the interview and that she felt the support/concern of the other women in the group. In fact, one of the women offered to escort her to the hospital, a 10-minute bus ride from the HSMM site. After discussing the situation with Katie, and the facilitator, the researcher decided to proceed with the focus group interview, knowing that the public health nurse was in the room next door. The researcher offered to drive the mother to the hospital at any time should the rate of her contractions change over the course of the interview. This decision reflects a "power with" as compared to a "power over" approach (Labonte, 1994). Both the researcher and the facilitator respected Katie's views, desires, and lived experiences related to her previous labors. In a "power over" approach, the professional staff would have "educated" Katie on the risks associated with her participation in the group interview, ultimately coercing her to go to the hospital, against her wishes and better judgment. This quotation from the laboring mother provides additional context:

> Katie: *I'm due now! My contractions are ten minutes apart!*
> Group response: *I-yi-yi!*
> Katie: *I've been kind of contracting since four o'clock this morning. This is the longest time I've ever waited. My last one [labor] was only two hours.*
> HSMM participant: *I told her* [Katie] *I'd make sure I got her home, because I can catch the bus along the way. And we're close to the hospital, I can go with her. I*

> *have to go that way to go home, so that's why I said she's only a block from the hospital. I'd make sure she at least got to the hospital.*

In the following quotation, Katie described why her experience of labor--actually feeling the contractions--was very important. She began by discussing the difference that HSMM had made in her life:

> *The difference Healthy Start made for me? It gave me a lot of information, it gets me out of the house. It changed my whole life a lot. I'm a mother of four and things I've learned here, I never knew before. And I'm making progress in my pregnancy all the time. I'm getting to know my baby inside and what a contraction actually feels like. I never had that before--the baby just popped out! With my other pregnancies, I never knew anything about contractions. As soon as I felt something, I went to hospital, and a couple of hours later I had the baby. And, now, I've had contractions for almost twelve hours, and I've never actually experienced contractions until I came to Healthy Start. You're supposed to go to the hospital when they're five minutes apart. I never knew that. I just went when I felt the pain, and I had the baby. Now, they* [the contractions] *are ten minutes apart, so hopefully I'll have this baby tonight!*

Katie actively participated in the complete focus group interview and on leaving the site, late in the afternoon, her contractions were approximately eight minutes apart. The researcher offered Katie, and another participant, a ride home but they declined. The next day, I learned that the laboring mother and her companion had used their bus tickets (provided by HSMM) to go directly to the hospital. Early that same evening, Katie gave birth to a healthy baby girl weighing seven pounds, 13-ounces. Retrospectively, Mary provided some additional information:

> *Do I see the mom [Katie] who was in labor during the focus group interview? Oh, yes, she still comes to the Evergreen drop-in sessions. She's doing really well. And Baby is exquisite! Her name is ______. Mom comes regularly to the postpartum program. She never misses. And this is a mom with five children. She just loves it and she's made friends there.*

The focus group interview at the Evergreen Community Centre, especially the opportunity to support Katie, along with the other members of the group, was a very powerful and memorable experience for the both the researcher and the facilitator.

5.3. Participant Women's Experiences of the Drop-in Sessions

Focus group participants were asked to discuss their experiences in HSMM. An initial probe was, "When you walked through the door of the drop-in session for the first time, how did you feel?" The participants' responses varied. Some recalled feeling nervous and scared, while others stated that they were excited by the prospect of getting out of their houses and meeting new people:

> *I guess in a way I was kind of excited. A friend from another site told me about Healthy Start and she more or less told me, 'You better be there,' so I said, 'Okay, yes, I'll be there.' So I came, and I met her here, which made me feel good because at least I knew somebody. After being there for that hour and a half, I felt it interesting, and I knew that the next time that I came--they tell you what they're going to be doing next time--so for me I felt excited: 'Oh, yes, okay. I can't wait for the next two weeks to learn what else.'*
>
> *When I first came, I felt excited. I just sat down and I listened to everybody and I never said nothing. Now, I don't feel nervous at all, because I've already heard everybody talk. I have things that I'm supposed to do on ______ afternoons; I'm not supposed to be here. But, it's more important for me to be here, so I come.*
>
> *When I first came, I was hesitant in coming, but my sister insisted that I come. I just came along and sat there the first time and listened to everyone else. But now when I come I participate once in a while; it depends how I'm feeling. I just enjoy coming; it gives me something to do; some place to go. Usually, otherwise, I'd be just sitting at home watching TV. Now, it gives me something to look forward to. I look forward to coming through the door and seeing, okay, who's had their baby in the last two weeks? Who's new to the group? It's really fun!*

Two of the participants acknowledged HSMM program staff's ongoing efforts to create a comfortable and welcoming environment where shy people could feel at ease:

> *I think the first time I was shy--shy most of the time. And I know the workers, like the dietitian, as soon as you walk in, it's like; 'Oh, hi! Have some juice!' They give you a whole effort to be at ease, but I think I wasn't the first few times. I just didn't know . . . . But, now it's like, when I see their* [other participant's] *faces, and I see them other places too, I stop and I'm brave enough to talk to them.*
>
> *I love to meet new people so I wasn't nervous when I first came here, I don't think. It was such a welcoming experience with the facilitators. They made you feel welcome, and the moms too. It's like we all have something in common. We're all pregnant, and we're here for that purpose. Like I said, it breeds a familial type of setting, and I look forward to these days. If I have any other thing*

> *to do on a ______ afternoon, when I'm supposed to be here, I cancel it, because this is a priority for me.*

The above quotations begin to paint a picture of HSMM team members, through the experiences of participant women. The evolving picture is consistent with the "midwife-teacher" role discussed by Belenky et al. (1986). This is in sharp contrast to the traditional role of a "teacher-banker," described by Freire (1971). Midwife-teachers at HSMM function as effective problem posers and questioners in order to incorporate people's lived experiences into the group discussion. As participants realize that they are not alone they move more easily beyond feelings of isolation and powerlessness. Research findings suggested that HSMM team members rarely elevated the group discussion at the drop-in sessions to higher-level topics such as an analysis of societal forces and an understanding of participants' roles to challenge those forces. That type of critical analysis takes time. According to Labonte (1994), "it is less reasonable to expect that groups being newly formed [or time-limited] should quickly turn their attention to issues extrinsic to their own group dynamics" (p. 64).

The focus group participants were asked, "If I had been in the program with you, what would I have seen you doing at the drop-in session?" Although their responses varied considerably in length, the participants suggested that initially they were more likely to observe what was going on than they were to speak. The mothers who "sat and observed" emphasized that even though they may not have had much to say at the drop-in session, they were indeed learning, as revealed by the quotations:

> *Just sitting and listening to the women.*

> *You would observe me observing.*

> *Probably if you were in a session with me you'd see me eating, checking a name, just taking it all in, taking in as much information as I can. I just found that I'll participate if we're doing group discussion or stuff like that. It's just people telling that already have kids, explaining about the stuff that they went through, or how this one's so much different than their last pregnancy. I find it really amazing how one person can have two totally different pregnancies. And, I just love the facilitators that we have. They make me feel very comfortable and every question they have been able to answer for me.*

> *I'm an observer. I* always *observe. I get all my information on all these things. I just usually sit there and listen. If I have a question, I ask. And if I have a problem with my pregnancy, I go to the health nurse, with my diet, I go to the dietitian. I'm more like a person that asks more questions and needs more answers. Especially, that I'm thirty-one and I never had a child before, so I was really concerned going through this by myself. Basically, I come here and get information and I get help.*

The feminist literature suggests that observation and listening serve an important function for women as they strive to find their own voice (Belenky et al., 1986): "When women watch and listen to themselves, they begin to notice inner contradictions; they watch and listen to others and begin to draw comparisons between their own and other people's experiences" (p. 85). Listening to others is, to a certain extent, self-serving. It is a way of learning about the self without revealing the self in a group setting. Belenky et al. (1986) maintained that gathering observations through watching and listening was the precursor to reflective and critical thought.

A series of probes asked focus group participants what difference the program had made in either their lives or in the lives of family members. While the women's responses tended to be very individualistic, depending on their personal circumstances, sub-themes related to the knowledge gained, demonstrated support of peers and program staff, and an increased sense of personal control over the physical and emotional changes associated with pregnancy:

> *I haven't had a child for seven years and this is another experience. I guess because they* [the pregnancies] *are so far apart. I'm* really *scared especially going through this by myself. I'm actually by myself with my kids so it's great being around with other mothers that are going through the same process that I'm going through.*

> *I started coming in August. My friend brought me. I'm probably eating healthier. And I've learned more about what's involved in labor and all that. Before, I didn't know that much. I just figured that you sort of just push the baby out. Because with my third baby, I didn't have much pain. I was only in labor for a couple of hours. But now I hear about all the pain that's actually involved; I hear about back labor and about all these medications.*

> *Being pregnant is incredible. I read an article that's called 'The Incredible Shrinking Brain' because you keep forgetting everything and it's really true. So when Alice* [the peer outreach worker] *calls me the morning of Healthy Start, it's like, 'Okay. Is it today? Have I got the wrong day?' Just the phone call from Alice*

> *to remind me, even if I just get it on the machine, and I don't talk to her, it's like 'Oh, good. It is right.'*
>
> *I had a lot of changes and stuff like that, and one day I was crying, one day I'm happy, and I was driving myself crazy and driving my partner crazy. So he said, 'Go out and do something. Find something.' And so I found you guys, now I'm here, and everything is way better, and he's so much happier because I'm happier. And it's really filled a lot of emptiness and it gives me a sense of support. Somehow my life is a whole lot better; talking to people in the same situation, it's a whole lot better. And I'm happy.*

When describing the impact of HSMM on their lives, three of the focus group participants suggested that the program had a positive influence on their lives. Although the quotations are somewhat vague, participants implied that the their ongoing participation in HSMM facilitated their making healthy lifestyle choices and contributed to their adopting a more positive outlook on life:

> *I don't know. Everything changed. I had to change. I'm young. I have a baby to take care of now, so I can't be young anymore, I guess, not for a while anyway. I think it* [HSMM] *made my life better. It turned me to positive ways.*
>
> *When I first started coming I was in my first trimester. When I became pregnant, I quit smoking. So by the time I came here, it just helped me to stay that way, because we watched programs on what smoking does, even secondhand smoking. It just helped me to stay on track.*
>
> *I've been going through a depression, and they were just getting ready to put me back on medication, and I found out I was pregnant, so I wouldn't allow it. I said I wasn't going on any kind of medication again. And I was just trying to find positive outlooks, things to help keep me positive. If I wouldn't be coming to these classes, I would have been spiraling . . . . And I know that I have a higher chance of spiraling after the baby comes, but I've got more people to reach out to now. Not just socially, but with the peer outreach worker, the dietitian, the public health nurse. Medically, I've got more support now as well.*

In summary, when describing their experiences in HSMM, participant women highlighted the knowledge gained, demonstrated support from peers and program staff, and increased self-confidence and capacity-building that resulted from their participation in the group process.

5.4. Learning New Things

Sarah, the HSMM manager, shared feedback that she had received suggesting that participants were acquiring a lot of new information at the drop-in sessions:

> *There has been different feedback over time. I remember a nurse from a community clinic phone one time. She said; ' ____ comes to our clinic a few days after she has been to a Healthy Start drop-in session. I bet you don't know how much she is learning!' And one of our staff members replied, 'No, I don't think we do, because she never says anything.' And the nurse said, 'I know she never says anything, but she's just absorbing like a sponge, and she tells it back to me, and she can almost regurgitate the whole thing.' It's full-scale learning.*

In the focus group interviews, participants confirmed that the knowledge they acquired at the drop-in sessions was key to their experience. First-time mothers, as well as experienced mothers, considered the opportunity to learn of prime importance. A sample of their responses follow:

> *I learned lots and I like coming here. I look forward to the cooking and stuff.*
>
> *It's a lot of learning for us. Just how to take care of your baby after it's born and how to take care of yourself as well.*
>
> *The difference for me is that I eat better now. I cut out a lot of junk. I know a lot now that I didn't know before. I'm glad I know about it now. It made a big difference in my life--not only with me, but with my partner. We seem closer now that we talk about the changes I'm going through, the personal changes that I'm going through. He understands it now--why I have these up and down emotions and swings.*
>
> *It's an experience. I've learned so many things about childbirth and being a single parent. This is my fifth child, and the program really helped a lot. Learning about childbirth, breastfeeding, learning to take care of your body while you're pregnant, and different things you feel while you're pregnant. And nutrition is a great thing for me, because I've only gained eight pounds through my whole pregnancy. With my other pregnancies, I gained fifty, thirty, forty pounds. I used to gorge on everything because I never knew anything about nutrition. But, now that I know, I didn't gain that much.*

Mary reflected on the learning that participants acquired through the group process. She felt that the diverse ethic composition of the groups contributed to participant learning. For this reason, Mary expressed the sentiment that multiethnic programming was more effective in HSMM than ethnic-specific interventions. She stated emphatically that she hoped that HSMM staff would not segregate individuals and/or groups on the basis of ethnicity or cultural backgrounds:

> *I would say that the ones that attended regularly and who made a commitment to being there would have gained self-confidence--they would have gained a level of comfort in groups that they would never have experienced before. And, I don't know where else they would ever have that experience. Particularly, the experience that comes with being in a group of people representing so many different cultures. The fact that native, non-native, immigrant, non-immigrant, women of all different backgrounds can be together and for a common purpose is really, really important. So, I think it's so important that it* [programming] *isn't segregated into racial groups or ethnic groups. Although it may be harder this way, they get to see each other; they get to eat together; they get to observe each other.*

An experienced mother described how HSMM program staff supported participants to apply the knowledge that they gained in the drop-in environment. She used her experience with breast-feeding to illustrate her point:

> *It's not my first baby, so there wasn't an awful lot that I needed to learn. But, with me a big thing is trying certain things that I haven't tried as a mom--like the breastfeeding. I'm really finding I'm doing a lot and my baby is a couple of weeks old. So, it seems like I'm learning things in the program and stuff. It sets your mind on the right way, that you have people encouraging you to get going, to do what's healthy for the baby. When you're on your own, it's much harder.*

A review of an unpublished HSMM document suggested that the information that women gained at HSMM was indirectly changing the interaction between participants and their physicians at regularly scheduled prenatal check-ups. This, in turn, increased their internal feelings of control and decreased learned helplessness. The author of the document reported these findings:

> In response to a question asking a sample of HSMM participants (n=15), attending 2 HSMM sites, how often they visited the doctor while pregnant, their answers ranged from less than 5 to 15 appointments. The woman who went to the doctor five times said that she may have gone more but she did not find out that she was pregnant until she was 3 months. The women who went more than 5 times gave the following reasons: spotting, general complications, 'because the doctor said', and sickness.
>
> The women felt that Healthy Start may have indirectly played a role in their doctor's visits, not necessarily in the number of visits, but in knowing what to expect. Discussing different topics, and hearing other moms' experiences at the

> drop-in made the moms more aware of what to expect and questions to ask their doctor. (Dyck, 2000, p. 7)

Dyck (2000) reported that the same sample of HSMM participants (n=15) found practical suggestions and information on breast-feeding, acquired at the drop-in sessions, to be very helpful. In particular, HSMM mothers reported that their knowledge of the following factors positively influenced their decision to breast-feed:

> It saves money
> It's convenient
> It's not necessary to pack bottles when going away
> Knowing how to relieve sore nipples
> Knowing that your body is better than the bottle
> That you should have no shame--breastfeed anywhere
> You should be proud to be breastfeeding--it's a gift
> It helps you to bond with your infant more. (Dyck, 2000, p. 9)

Other historical program documents summarized interview findings with participants where they were asked if they used the HSMM "question can" to obtain information, or answers to specific questions at the drop-in sessions. The authors reported that participants' responses to this question were mixed:

> Yes . . . because you can get suggestions and request certain things confidentially.
> No . . . because you can ask the question during the drop-in. If you are thinking it, probably someone else is also. Participants preferred to ask questions privately in the last part of the drop-in. Other "no" responses included: can't think of questions; have nothing to say; sometimes too much is said and the information is over-whelming. (Dyck, 2000, p. 9)

Current program files were reviewed in an effort to learn more about the types of questions that participants placed in the HSMM "question can." A great deal of variety was obvious with some indication that the women used the "question can" to raise issues of a highly personal or sensitive issue. It was apparent that the participants also relied on the "question can" to provide feedback to staff. A sample of participants' questions/ comments, transcribed from the original entries, follows:

> *Why do women get "diabetic" only when they are pregnant? Then it goes away after the baby's born?*
>
> *My body feels tired and sore. What foods should I eat?*
>
> *Shaken baby.*

> *This is my first visit here. I like it, very informative. Keep up the good work. Bless you all. Signed, [Happy Face]*
>
> *Do you give baby clothes?*
>
> *Good group TALK.*
>
> *When do we stop having sex? Also, is it safe for Baby to have lots of it?*

5.5. Gaining Self-Confidence

Israel et al. (1994) defined individual or psychological empowerment as individuals' ability to make decisions and have control over their personal lives. There are obvious similarities between individual empowerment and other constructs such as self-efficacy (Bandura, 1982) and self-esteem (Rosenberg, 1956). All three constructs emphasize the development of a positive self-concept or personal competence. According to Israel et al. (1994), "empowerment at the individual level combines (1) personal efficacy and competence (2) a sense of mastery and control (3) a process of participation to influence institutions and decisions." (p. 151)

Sarah, the HSMM manager, shared feedback during her interview to suggest that participants were gaining self-confidence through the course of their involvement with HSMM. In the second quotation, she implied that changes in participants' confidence levels would be difficult to assess. According to Sarah, women were not accustomed to discussing the impact of the program in this way:

> *And then there was a woman from another agency and she said, 'Sarah, I don't know what the heck you're doing over there at Healthy Start, but it's something really amazing, because I can tell the difference when the women come through our agency doors. I can tell which mom is a Healthy Start mom and which isn't.'*
>
> *There's another woman I know who credits Healthy Start with having built her confidence enough that she then got a job. She says she got her job because of Healthy Start. We wouldn't have seen that cause-and-effect necessarily, but she did, and it linked her with a site in a community. So, she got hired by that site where we functioned. Without her Healthy Start experience she wouldn't have known about the site; she wouldn't have developed the confidence to then put in an application . . . so many subtle things. It's hard to capture on a site-by-site basis. Women aren't likely to say, 'I feel more confident,' because that just isn't the way that things get phrased.*

Mary recalled a one-on-one discussion with a woman at the conclusion of the Willow Community Centre focus group interview where the issue of self-confidence was raised by the participant:

> *There was one woman who had been attending the Willow site and she had been there for two pregnancies and was very sad to leave. And I recall her saying in the focus group--it was very poignant--something to the effect that prior to attending Healthy Start, she had never spoken out about anything in her life--to anybody. And, that she learned through the group process to be able to speak about her feelings, and about experiences, and to have them valued. She just expressed it so beautifully . . . that without that experience she would never have considered participating in a focus group. But, because she had learned so much and felt so much more confident in herself--so I recall that particular woman very well. I think about her often because she said something that was so beautiful.*

Mary went on to explain that the woman was aware that her relationship with her children had been positively influenced by her involvement with HSMM:

> *And also that was a side benefit, because the* *real* *benefit was her relationship with her children. If I'm not mistaken, she'd had other children that were apprehended, and she changed her lifestyle and was supported in those changes in her lifestyle by attending Healthy Start. I just remember how important that experience was for her, and more so than just learning about pregnancy and delivery and healthy food . . . everything related to pregnancy. There was also a side benefit for this very shy woman who'd had lots of tough, really tough life experiences--she had gained some confidence. I often wonder what happened to her.*

The above quotation suggests that although HSMM participants may be emotionally or intellectually isolated they begin to actively analyze their past and current interactions with others at the drop-in sessions. While this participant had not actually spoken out, she engaged in observation and listening prior to sharing her lived experiences in the group setting. She was "gaining a voice" and a knowledge base from which she could actively participate in the group dialogue. This matter has been addressed in Belenky et al. (1986): "As women become increasingly skillful at executing procedures for obtaining and communicating knowledge many experience an increasing sense of control" (p. 96). As women's sense of control increases, their world appears more manageable. Feminist researchers, including Belenky et al., caution that although silent women develop language they do not cultivate their capacities for representational thought. The researchers state that language and/or literacy alone does not automatically lead to reflexive abstract thought. Belenky et al. (1986) explained the relationship of group dialogue to reflexivity:

> In order for reflection to occur, the oral and written forms of language must pass back and forth between persons who speak and listen or read and write--sharing, expanding, and reflecting on each other's experiences. Such interchanges lead to ways of knowing that enable individuals to enter into the social and intellectual life of their communities. Without them, individuals remain isolated from others; and without the tools for representing their experiences; people also remain isolated from themselves. (p. 26)

When reflecting on the issue of self-confidence and the impact of the group process on increasing participants' confidence levels, Mary shared a story based on a participant's experience in HSMM:

> *A participant, a young woman, gave birth to a child with quite a severe cleft palate. She had been attending 'Baby* Steps*'* [HSMM's postnatal program]*--she never misses. Yesterday, she was able to talk about her experience a little bit. Her son is going in* [to hospital] *for his first repair. And she was able to talk with the group about her feelings that she had been presented with a baby that wasn't perfect. . . . And, also that she got a lot of support and comfort from coming to the group. So, I'm thinking if you can extrapolate from that, other women who maybe have disabilities or cultural issues or whatever, just the fact that the drop-in is so welcoming, and so open, and so nonjudgmental. There's just an opportunity to be there, and also to be exposed to other things, and to be able to develop enough of a relationship to ask those kinds of questions. She felt comfortable enough to give permission to the other moms there to ask questions about the cleft palate and the baby's harelip.*

This quotation emphasizes that the agenda for the drop-in sessions must be carefully determined to ensure that participants have ownership for their own "curriculum." The HSMM curriculum is not prescribed--it emanates from the listening process. As the above quotation illustrates, curricula is built around an opportunity for people to develop trust and to share real life issues and emotional concerns.

Contrary to Sarah's opinion expressed in an earlier quotation, HSMM participants did discuss the impact of the program on their self-confidence. In fact, four participants shared their thoughts on this issue. Their comments provide insight into the efforts of the "midwife-teachers" to sensitively draw information out of participant women:

> *My experience with the program the first time I came here, I was really shy, never talked to anyone. I just sat there and looked around. After a couple of sessions I started loosening up and I started talking to people. And the more I came out, the more I started being friendly and started talking to other mothers. It was just an experience for me, because when I was married I always stayed home and never met any other mothers that were in the same position. So, it was a great experience for me to find Healthy Start.*

> *For me, they* [the program staff] *made it seem as if they wanted you to keep coming back. They wanted to make it exciting for you, and they did. It worked! It kept me coming. There were a couple of times when I came by myself. Now I find I like to help here, if you're friendly, and not just sitting there like a lump, you get to learn more.*

> *Me too. I look forward to coming back. I take all the information I've absorbed to my children because my children want to know what's happening when I come here. They want to know, 'Where do you get all these milk coupons from?,' and I tell them. My oldest one is thirteen and he's really supportive of me having this baby. I was going to give it up for adoption, and the bigger I got, the more feelings I got for the baby. And I come here and share it with everybody, and I just feel sad leaving the place and thinking, I'm not going to be seeing these people again for another two weeks. And I try to say, 'How about we get together _____? How about we talk on the phone?' So it's sad; sometimes I feel sad when I leave here. I look forward to coming here all the time, and when I do leave, it's just saying, 'Oh, I'll be back. Now they're saying, "Good luck! Hopefully see you.' And I say, 'Oh, I'll be here, don't worry. Don't worry, I'll be back.' So, I feel really confident in this program.*

> *I just feel a lot more confidence in having the baby now instead of being all scared and, oh, what's going to happen? What's going to go on in the delivery room? Or, what am I going to experience just throughout the pregnancy? And I feel a lot more confident now.*

While not mentioning "self-confidence" per se, one focus group participant spoke proudly of the feelings of accomplishment and increasing self-confidence that she experienced as a result of her participation in HSMM:

> *I feel like I can't wait to come back in two weeks. I guess I feel like I've accomplished something. So I figure maybe if I'm doing this on my own, I feel more confident in myself. Leaving and going back to my common-law, I can't wait to go home and tell him all I've learned . . . . You can purchase those Meal Bags and they give you the recipe, so here I am collecting up all these recipes.*

The quotations above address interpersonal empowerment at the level of the small group. According to Labonte (1994), the group is "where we forge our identities" and "where we create our purpose" (p. 62). Wallerstein (1992) stated that small group development gives birth to the essential characteristics associated with empowerment: control, capacity, coherence, and connectedness. The sphere of small group development in HSMM is discussed further in Chapter 6. For HSMM participant women, the power of the group was in creating and strengthening linkages to other women sharing similar life circumstances. The nurturing nature of the group was in validating that the women were not alone in their daily struggles. Group strategies focusing on social support, self-care, and capacity-building should not be under-estimated. Women who are empowered in the group setting are able to participate in higher-level community organization and coalition efforts. However, Labonte (1994) pointed out that because the small group primarily deals with the individual, and individual problems, the deeper causes of powerlessness (e.g., poverty) may remain hidden and not addressed. He emphasized the importance of pushing into other spheres of The Empowerment Holosphere (i.e., community organization; coalition-building and advocacy; and political action) in order to address the social and economic factors contributing to poverty and powerlessness.

5.6. Making Friends

The concept of social support--although it was not the focus of this chapter--is another variable that has relevance to an empowerment model (Figure 2.4: Powerlessness and Empowerment). Extensive research suggests that social support may directly enhance health and protect people from the negative consequences of stressful situations. For example, Israel et al. (1994) stated that

> In those communities where members provide one another with emotional support (empathy, loving, and caring); instrumental support (tangible aid, services); informational support (advice, suggestions, information); and appraisal support (feedback, affirmation, social comparison) members would be expected to be at less risk of the negative effects of stress than in communities where such mutual support does not exist. (p. 154)

Judy, the dietitian on the Willow Community Centre team, spoke at length about her perceptions of the friendships that grew out of HSMM. To illustrate her point, she shared a poignant story involving a HSMM participant whose baby has recently died:

> *We had a mom whose baby died. She came with a friend to the next group meeting, and the friend phoned us and said she was going to be coming. So, we have a pretty quick system, when moms call us so very quickly and let us know what happened. It was very different, but we said a prayer for the baby all together. We are very careful about saying prayers because we know that we have different religions represented at the table, so we tried to silently say a prayer for the mom and for the baby. It was very difficult for the mom. She did not cry during the drop-in--some of us were in tears, and her friend was in tears. She was very stoic, and I think probably later on felt the support of the group. I think she was feeling really sort of numb that day in the group.*
>
> *She did come back a couple of times after that. And she really did feel that the group was a support. Pardon the language, but one of our doctors spoke of 'a very shitty life syndrome'--that some people just have really difficult lives. It was shortly after that that the mom's house burned down as well. She lost everything and had to move. So, I think that's the way it is with HSMM. These are women who really have strong needs and being able to bring people together and provide them support, not just as a single person, but as the whole group. Even if the participants don't make individual connections within the group, they do make a connection with the group itself.*

Beth, the HSMM dietitian and a member of the Evergreen Community Centre team, also reflected on the strong ties that one woman developed with the other members of the group. The following quotation describes the participant's efforts to continue participating in the drop-in session even though she had moved and now faced a significant commute. Beth's comment that the participant women refer to HSMM as "their" program is indicative of a high degree of degree of community ownership (Rubin & Rubin, 1992):

> *I can think of one mom. She had been coming for a while--she was a chef. She's Aboriginal and before she delivered the baby she moved back to the reserve because that's where she wanted the baby to be born and raised. But she drove back, every two weeks, I think it was an hour-and-a-half or two hours from the reserve to Winnipeg, just so she could come to the drop-in, because she said, 'It's my drop-in. I won't miss it.' That, in itself, is a testament to the commitment, that the moms feel that it's theirs: 'Our Healthy Start' or 'My Healthy Start' . . . . We hear that all the time and that's what we want to hear!*

A focus group participant described the feeling of mutual support at the drop-in session and, in the first quotation, she described HSMM as *"as a bonus . . . a blessing in my life."* She introduced the concept of empathy, described by Wallerstein (1992) as an intermediate variable linking personal and community empowerment (Figure 2.4: Powerlessness and Empowerment). In the second quotation, another participant described the support that resulted from sharing the experience of pregnancy with others in similar circumstances:

> *It's informative, it's very informative. The coupons come in handy and the food is always good. And it's a friendly type of setting where we get to know the other moms, so we make new friends. So, you finally have somebody who can empathize with you. I've been coming here about the same time as ______ and ______. I'm due in one week and four days. It* [HSMM] *has been a blessing . . . a bonus in my life.*

> *Basically all I did was just stay home with the kids. And when I found out I was pregnant I didn't know what to do or who to turn to. And the next thing you know, my friend says, 'Come to Healthy Start with me,' and I said, 'What is Healthy Start?' And then she goes, 'Just for mothers, pregnant mothers.' So I came, and it was actually comforting being around people that you didn't know and you got to know. And ask them questions, '_______ you're pregnant, and how does it feel?' So it was actually comforting asking mothers how they were experiencing their pregnancies. And the nurses helped a lot, the dietitian helped a lot, so actually, I'm really happy that I found Healthy Start.*

An other focus group participant--an experienced mother--described the mutual support she felt from other women in HSMM and the significance of the program in her life. She compared her past pregnancies to her present experience with HSMM:

> *This is my second time* [pregnancy] *coming here. It's a great support, being around a lot of people in the same situation. I didn't have a baby for fifteen years, so it's like my first one all over again. Way back then, I don't remember any support groups. This is great! The coupons are good too! It gets me out of the house. And it familiarizes me with all the aches and pains that I forgot about. It's all coming back again..*

In the following quotation, a focus group participant candidly admitted that her involvement in HSMM had assisted her in dealing with the shock associated with an "unplanned" pregnancy:

> *When I found out I was going to have a baby, I was just devastated. I have a daughter and she's in school all day. And I'm a career person. When I found out I was pregnant, I didn't know what to do. So, I chose to come here. And I'm glad I came. It drove the devastation out of me. I knew that I wasn't alone with what I was going through. It helped me to slow down, to focus on what was happening, and to enjoy this pregnancy. I have been enjoying it. I'm just beginning to finally comprehend what this is all about.*

In summary, HSMM participant women suggested that social support, described above as interactions with peers and team members, communicated information, esteem, aid, and emotional help. According to Stewart (1990b), "these communications may improve coping, moderate the impact of stressors, and promote health and self-care" (p. 7).

5.7. Significance of Food and/or Coupons

Research findings confirm that disadvantaged women's experiences of pregnancy are inextricably linked to both the social context and stresses of their lives. Poverty-induced food insecurity is a key factor in compromising the well-being of HSMM participants. According to delegates attending the 1996 World Food Summit (Agriculture and Agri-Food Canada, 1998), "Food security exists when all people, at all times, have physical and economic access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life" (p. 5).

Slightly over 75% of participants in HSMM reported that "it's hard for them to get enough food" (Healthy Start for Mom & Me, 1999b). Three-quarters of the participants stated that they used food banks on a regular basis, and just under half indicated that they needed to obtain food from relatives or friends. The food insecurity experienced by these participants is indicative of much broader insecurity in terms of access to a wide range of essential health/social services and resources. It is not realistic to think that a single prenatal nutrition program can provide a solution to longstanding health inequities. Programs like HSMM cannot provide comprehensive coverage for disadvantaged women and their families, nor can they offer integrated and sustainable solutions to food insecurity. Israel et al. (1994) warned that "access to nutritious and affordable foods in low-income communities is not determined by the individuals residing within them, but by processes of production and distribution that reflect regional, national, and international corporate and government interests" (p. 156). Recognizing the powerful link between income and food security, Tarasuk et al. (1998) called for the development of national standards to guide provinces and municipalities in their restructuring of benefits so as to meet basic needs: "Without improved income support for families on social assistance and those struggling to support themselves in low-waged jobs, the nutritional health and well-being of family members will be jeopardized" (p. 24).

The group interviews conducted at the Evergreen Community Centre site and the Willow Community Centre site did not focus on the significance of food and/or coupons in the program. Participants tended to address these issues in their responses to other questions. Therefore, it was difficult to separate their experiences with food and/or coupons from their overall experiences in the program. In contrast, multiple HSMM program documents addressed the topics of food supplements and/or coupons at length. Further, evaluation reports explicated the experiences of participants with these two components of the program. Therefore, historical program documents have been incorporated into the following discussion on the significance of food and/or coupons to HSMM participants. It is important to emphasize that only when issues surrounding confidence, skill development, and capacity-building had been addressed was it possible for HSMM team members to "teach" participant women how small changes in food choice and preparation can have a positive effect on their diets.

A focus group participant who experienced nausea and morning sickness in the first trimester of her pregnancy found the HSMM Meal/Recipe Bags to be particularly helpful:

> *I wasn't able to do a lot of cooking right from the beginning, so the meals in a bag have been helpful. I haven't been able to cook meat at all, and my morning sickness has started all over again. So, at least there's one guaranteed meal that I know I can get that's homemade every other week. It helps.*

A second focus group participant indicated that although the coupons were important, they were not the most important reason for her attending the drop-in sessions: *"Definitely, I'm making friends. We share everything. I look forward to coming to the program every two weeks. It's not only the coupons. If they even didn't have the coupons, I'd probably still be coming too."*

HSMM program documents reported findings of a previous focus group interview with participants (n=15) attending two sites. Participants were asked if they purchased the $1.00 Meal Bags at the drop-in sessions. A summary of the responses of the nine women attending the Evergreen Community Centre site follows:

> All women interviewed said that they purchase the Meal Bags and find them very helpful. A common addition to the 'yes' was, 'if I remember.' The Meal Bags that the women liked the best were 'Supper in a Casserole' and 'Chicken in a Flash.' The nine women stated that they do buy the extra perishable ingredients called for in the recipe. In general, the extra foods are often ingredients that they already have at home. All mothers agreed that the recipes were easy to follow. (Dyck, 2000, p. 4)

According to archival information, the nine Evergreen Community Centre participants were also asked what stopped them from purchasing the Meal Bags more frequently. The women replied that either they "forgot," or that they did not have the necessary extra money. When the same nine women were asked "What have you learned about cooking and nutrition at Healthy Start," they replied:

- Short cuts and easy recipes
- Everything
- How to eat good--quick healthy foods
- Snacks and how to prepare them
- Healthy recipes
- How to eat more vegetables
- Good, fast and cheap meals (Dyck, 2000, p. 4)

The participants indicated that they would like HSMM to provide additional recipe information and to invite mothers to share their favorite recipes with the other participants at the drop-in session.

Program documents revealed that HSMM participants were questioned about their use of a food bank in a previous focus group interview. The findings showed that the majority of the women attending the Evergreen Community Centre site used a food bank, although not necessarily on a regular basis. The few who did not indicated that they "had enough money" and "felt that other people needed it more" (Dyck, 2000, p. 6). The mothers attending the food bank stated that they often received unfamiliar food (e.g., canned spinach, cranberry sauce, and powdered milk) or poor quality food (e.g., flour containing silverfish and bugs). The research by Tarasuk et al. (1998) documenting food insecurity among women and families using food banks in Metropolitan Toronto highlighted sub-optimal intakes of key nutrients. The authors reported "prevalences of inadequacy" for iron (38%), magnesium (31%), vitamin A (28%), folate (23%), protein (15%), zinc (12%) (p. 9).

A follow-up question asked participant women: "Do you want new recipe ideas for the foods that you use a lot?" Program documents revealed that HSMM participants from the Evergreen Community Centre site were interested in recipes for the following:

- Pasta--new sauces for spaghetti, other than tomato
- Rice
- Hamburger and liver
- Muffins and healthy baked foods. (Dyck, 2000, p. 6)

Historical documents reported that focus group participants from all sites responded positively to the idea of a HSMM "Cooking Party" where women would pay $5.00 and cook three 3 meals, of four servings each, to take home for later use. The authors stated that the women agreed to a suggestion to collect the money at the beginning of the month and to hold the "Cooking Party" toward the end of the month. The participants stated that they would like to be informed of the meals in advance. Some suggestions that appeared in the program documents included lasagna, shepherd's pie, and other main dish casseroles.

Program staff surveyed HSMM participants to learn more about their access to kitchen utensils and cooking equipment. Responses indicated that all of the 15 women interviewed had a fridge and a range. Approximately half owned, or had access to, a microwave oven. Seven of the 15 participants did not have a hand-mixer, measuring spoons, or mixing spoons. Just under half (6/15) did not own casserole dishes, nor did they have access to cake pans or muffin tins. This type of information was helpful in ensuring that HSMM team members had a realistic impression of the broader social and economic environment that determined participants' access to utensils and cooking equipment necessary for home food preparation.

Findings reported in HSMM program documents indicated that participants were asked that "If you could talk to the funders of Healthy Start (the federal and provincial government), what would you want them to know or understand about program participants?" The documents summarized the participants' responses and emphasized the significance of the milk and/or juice coupons:

- The moms need milk
- Milk is very expensive, and with the coupons we WILL drink it
- We are a lot of people who need the help and the resources

- Programs like this should not target just people on social assistance--other people would benefit as well. (Dyck, 2000, p. 12)

5.8. Sharing Information With Significant Others

The focus group interviews held at the Evergreen Community Centre site and the Willow Community Centre site revealed that many participants shared their HSMM experiences with significant others. A participant explained the process:

> *When I leave here I leave with more information than I actually came with. Now I know the stages of my baby's development, how it's progressing, and I go home to my boyfriend and tell him about it. Now he's at the point where he wants to come to these classes. He tried to come last week but it was all women. He didn't feel that comfortable. He told me when I got home, 'I wanted to sit and hear what you guys were talking about so I could learn more, but I was the only man, and that's why I left.' But I go home and I tell him what I've learned and it makes him feel closer with me and the baby now. He's the one with the information that I take home from these classes, he makes sure that I eat healthy, that I'm drinking milk and all that. With my last two pregnancies we didn't go to any classes. I went to my doctor's appointments and he tells me how big the baby is and all that. This time, it's different. My boyfriend wants to know about how I'm feeling and my emotions and my physical changes. He's really connected into it now that I'm going to these classes because I talk to him about it.*

This participant's partner was not comfortable attending the drop-in session as the sole male. However, by her sharing the information with him, both mother and father strengthened their connection to the developing fetus.

Two other focus group participants spoke of their disseminating the information gained at the drop-in sessions to family members and friends with positive outcomes:

> *I find when I go home I can't wait to tell my mom, my friends, and even my fiancée even though he doesn't tend to listen, but I tell him anyway. And something will catch his attention. He'll be like, 'Oh! What was that? I wasn't listening' But he's getting better at that now. He'll actually sit down; he'll come home and he'll be, 'So tell me, what did you learn? What's new? What's going on with the baby? What's going with ____ ? Who's all had there babies there?'*
>
> *I feel okay when I leave. I share a lot of information with my spouse too. But I guess with him there's certain areas that interest him more than others. He would never come either because there's so many women.*

Program documentation of focus group interviews conducted with HSMM participants (n=128) in January 1999 indicated that the women had raised the idea of increasing the direct involvement of dads in the program. The suggestion read as follows:

> Some participants would like the program to be more welcoming/relevant to dads; others prefer the program to be made up of mostly moms. Ideas of having 'invite the dad days' or creating an opportunity for moms and dads in the evenings may offer a compromise. (HSMM, 1999, p. 1)

In contrast, the findings of the focus group interviews conducted at the Evergreen and Willow Community Centres HSMM sites suggest that participants prefer the "mothers only" approach, although the occasional male in the group was not problematic. However, it was surprising to learn that the majority of the participants shared the information with their spouses and felt that in doing so they were benefiting from the program as a couple.

5.9. Suggestions for Improvement

Although focus group participants were specifically asked if they had suggestions to improve HSMM, few ideas were forthcoming. In general, participants were very pleased with the program as the following response suggested: "O*n a scale of one to ten, I give Healthy Start for Mom & Me a ten-plus.*"

In response to several probes from the facilitator, the participants provided the following suggestions:

> *More draws--give everyone a chance to win*
>
> *More baby things--maybe a clothing exchange*
>
> *More videos*
>
> *A better resource centre--more books that we can borrow that explain more about the baby; about what you're going through; about what to expect . . . that kind of stuff.*
>
> *When we go to 'Baby Steps'* [HSMM's postpartum program], *the milk coupons should be continued. Because when you're breast feeding they want you to keep your up with your milk, and things like that, but when you're on very low income . . . they should keep the coupons in 'Baby Steps' for the first year. Or, even just into the first six months. That's about the only thing I can see changing. Anything else that we ask for, it usually comes around one way or another.*

> *I agree with ____. The coupons should be kept going through. Because it's really important. I know for me, I've been able to save up enough that I'll be good for a little while, after the baby's born, but it still makes it really hard because I won't go out and buy that much milk. I'll buy a two litre or whatever, but if I don't have it, I won't go get it.*

At the time the focus groups interviews were conducted, the HSMM milk and juice coupons were not available to post-partum mothers because of resource limitations. However, a recent edition of the HSMM Bulletin (July/August 2000) stated that the policy had changed and effective July 3, 2000, post-partum mothers would receive the coupons for the first three months following the birth of their babies.

5.10. Section 2–Theoretical Constructs

Interventions at the level of Personal Care fail to recognize the complexities of human behaviour and ignore the crucial connection between individual behaviour and social norms and rewards (Labonte, 1994). According to Tesh (1988), they represent "a victim-blaming approach" to disease (p. 379). Although individual knowledge and attitudes may be necessary for behaviour change, they should remain secondary to environmental approaches including changes in the physical and social environment (McLeroy et al., 1988).

Despite the limitations of empowering interventions targeted at personal care, health promotion practitioners have a role in providing services at the individual level that minimize the effects of poverty. Empowering services should be offered that respect individual autonomy, are culturally sensitive, understand the psychosocial and socio-environmental context of the individual's concerns and problems, and increase the capacities of individuals to act upon the symptoms and roots of their distress (Labonte, 1993). An empowering approach was described by Reutter (2000) as

> listening to the impoverished to understand their experiences, acknowledging not only their constraints but also their strengths, exploring realistic suggestions and alternatives, and advocating for and with clients to access resources. Home visiting affords excellent opportunities for personal empowerment (Reutter & Ford, 1997a; Zerwekh, 1991). (p. 185)

Empowering strategies within the spheres of personal care and small group development build towards community organization and coalition advocacy. Within

HSMM, these "levels" of The Empowerment Holosphere--personal care and small group development (Figure 5.1) are the loci of much direct service activity including home visiting, nutrition counseling, and public health nursing interventions. Although these strategies are directed towards the individual, they are extremely important in offering social support and self-care to participant women.

5.11. Summary

This chapter focused on the experiences of participants in HSMM attending two drop-in sites--The Evergreen Community Centre and the Willow Community Centre. The findings confirmed that participants' experiences of pregnancy were inextricably linked with the social context and stresses of their lives. Poverty, social isolation, and a lack of resources were significant factors in participants' well-being. Women described challenging life circumstances and daily struggles for survival. In many cases, pregnancy exacerbated the chronic stress, chaos, and crises in their lives. Additionally, women spoke of multiple role demands that offered little space and time for themselves. In effect, participant women described the physical and social risk factors for powerlessness (Wallerstein, 1992).

Research findings highlighted a wide variety of factors that motivated disadvantaged women to attend the drop-in sessions and kept them actively involved in the program. Participants confirmed that the key features of HSMM's "Kitchen Table" approach (discussed in Chapter 4) were largely responsible for the program's overwhelming success in connecting with an audience traditionally described as "hard to reach." The contextual influences that facilitated group discussion and participants' readiness-to-learn included a safe, non-threatening physical environment; the provision of food and supplements; outreach services; needs-based information; childcare on-site; and a relaxed informal approach to program delivery.

Participant women emphasized that HSMM team members were the "life blood" of the program offering both information and support in a warm, friendly, and nonjudgmental manner. Participants' descriptions of program staff and community partners were consistent with the attributes of the "midwife-teacher" described in the feminist literature (Belenky et al., 1986). The educational dialogue approach employed by HSMM required facilitators to be effective problem-posers and sensitive questioners in order to incorporate participants' lived experiences into the group discussion. The tendency of some participants to "sit and observe" reflected ongoing efforts to learn about the self, without actually revealing the self. This was a precursor to the reflective and critical thought necessary for "conscientization" (Belenky et al., 1986).

When describing their experiences in HSMM, participants highlighted the knowledge gained, demonstrated support from peers and program staff, and the increased self-confidence and capacity-building that resulted from their participation in the group process. Many saw the drop-in sessions as a way to break the monotony of their day-to-day lives--for some it was a chance to get out of the house and offered an opportunity to do something "positive." Participants were doubtful that male partners would attend the drop-in sessions and they appeared to prefer a "women only" approach to prenatal programming. However, a surprising finding related to the tendency of women to share information from the drop-in sessions with partners and significant others. Participants suggested that this sharing expanded the mothers' support networks and strengthened the familial bonds to the developing fetuses. Immigrant/refugee women valued the opportunity to interact with Canadian women at the drop-in sessions and spoke very positively about their experiences in HSMM.

HSMM programming focused on the social, economic, and cultural environment of participants, rather than on health behavior alone. Drop-in sessions were accessible in terms of cost, culture, location, literacy, and childcare. HSMM attempted to address food insecurity of participant women through the provision of food and nutritional supplements. Nutrition information was needs-based and presented in an interactive manner that involved the hands-on preparation of nourishing and cost-sensitive snacks. While participants valued the opportunity to increase their knowledge of nutrition and basic food preparation, HSMM's "Kitchen Table" approach was a critical first step in addressing issues around skills, confidence, capacity, and readiness-to-learn.

The health promotion literature suggests that empowerment at the individual level (personal care) is closely linked with organizational and community empowerment through the development of personal control and competence to act, social support, and the development of interpersonal, social, and political skills (Labonte, 1994; Israel et al., 1994; Wallerstein, 1992). HSMM direct service activities including peer outreach, nutrition counseling, and public health nursing were very effective in strengthening social support, building capacity, and increasing the self-care of participants. The small group dialogue resulted in women recognizing that they were not alone in their problems. Over time, participants developed mutual identification and moved beyond feelings of isolation and powerlessness. Participant women described new and emerging feelings of empathy, support for peers, and an increased sense of control over their environment.

Chapter 5 describes empowering strategies at the "levels" of personal care and small group development. These strategies should not be under-estimated by health promotion practitioners. However, Labonte (1994) reminded that: "to the extent that self-help or small groups deals only with individuals and individual problems, the deeper structural causes of powerlessness may remain obscured and unaddressed (p. 64)." According to Labonte (1994), there were serious consequences associated with not pushing into the other spheres of The Empowerment Holosphere:

> Our experience of empowerment at the interpersonal and intragroup levels of society, where empowerment is experienced in a very essential way, may render us complacent to the more difficult process of working collectively to challenge power relations. Unless social relations are continually analyzed from a broader socioeconomic and historical framework, they may foster an odd social norm in which for many of us our primary social identities become forged in our disability, our disease, our relatively powerless social conditions. (p. 65)

In conclusion, the critical social research describing the experiences of participants in HSMM, combined with historical program documentation, suggested that women were successful in "talking across differences" to achieve a sense of common ground and purpose. In the case of HSMM, the process of community empowerment leading to social change began with the individual. An ancient proverb reflects the wisdom and foresight of HSMM staff and community partners as they laid the foundation for a new program focused on building community empowerment and health equity in Winnipeg's inner-city:

> Go in search of people, . . . begin with what they know, . . . and build on what they have. (ancient Chinese proverb)

CHAPTER 6

HSMM PEER OUTREACH WORKERS: BRIDGING THE GAP

6.1. Introduction

Chapter 6 is divided into two sections. Section 1 of Chapter 6 describes the vital role of HSMM's peer outreach workers in bridging the gap between professional staff and participant women. Although other team members engaged in the practice of "cultural brokering" (Jezewski, 1995, p. 20), this practice was fundamental to the role of the peer outreach workers as they were primarily involved in direct outreach and support to participant women. Program documents described the peer outreach worker as HSMM's "main service-provider" and emphasized that the peer outreach worker and participant women shared similar life experiences. This was instrumental to the success of the peer outreach worker in building trust, understanding, and support with HSMM participant women.

As the peer outreach workers' empowering practices with participant women becomes clear in Section 1, other personal and very poignant stories of empowerment emerge. The quotations describe the peer outreach workers' individual journeys of empowerment over the past five years as they made the transition from single mothers on social assistance to highly valued members of the HSMM team. The stories of empowerment at the individual level are interwoven with the empowering practices of the peer outreach workers at the program level. The health promotion strategies discussed in Section 1 primarily pertain to the small group development "level" of The Empowerment Holosphere (Labonte, 1994). However, the findings confirm that in bridging the gap between program staff and participant women, the peer outreach workers were "pushing" programming into the community organization and coalition advocacy "levels" of The Empowerment Holosphere. (Labonte, 1994)

The focus of Section 1 is on the lived experience of peer outreach workers who were attached to two HSMM sites: The Evergreen Community Centre and the Willow Community Centre. The experiences of other HSMM team members and key informants are brought into the discussion only when they pertain to the role of the HSMM peer outreach worker. The experiences of the mothers in the HSMM program, and their relationships with the peer outreach workers, are described in Chapter 5. HSMM team members' recollections have been elaborated upon using the researcher's memories and personal experiences of the prenatal nutrition program between 1995 and 1997.

Section 2 summarizes the theoretical constructs underpinning the research findings discussed in Chapter 6. The section begins with an overview of health promotion strategies operating at the small group development "level" of The Empowerment Holosphere (Labonte, 1994). The Empowerment Holosphere in HSMM (Figure 4.2), introduced in Chapter 4, is the organizing framework for the case study research on HSMM. In Chapter 6, the role of HSMM's peer outreach worker is positioned as a critical bridge linking the personal care "level" of The Empowerment Holosphere to the "level" entitled community organization.

The discussion pertaining to small group development is broadened in Section 2 to include interpersonal processes described in the ecological model for health promotion (McLeroy et al., 1988). This model which is similar to The Empowerment Holosphere (Labonte, 1994), focuses attention on both individual and social environmental factors as targets for health promotion efforts. Although Chapter 6 primarily addresses one "level" of The Empowerment Holosphere in HSMM--small group development--the "levels" of intervention should not be viewed as discrete. Rather, they are interconnected or overlapping and simply assist in the identification of the dominant emphasis of the health promotion program.

The chapter summary highlights the major research findings related to the peer outreach worker' practices of "cultural brokerage" (Jezewski, 1995, p. 20) and links the findings to the theoretical constructs identified in Section 2.

6.2. Section 2–HSMM's Peer Outreach Workers: Bridging the Gap

6.2.1. Sphere of Small Group Development

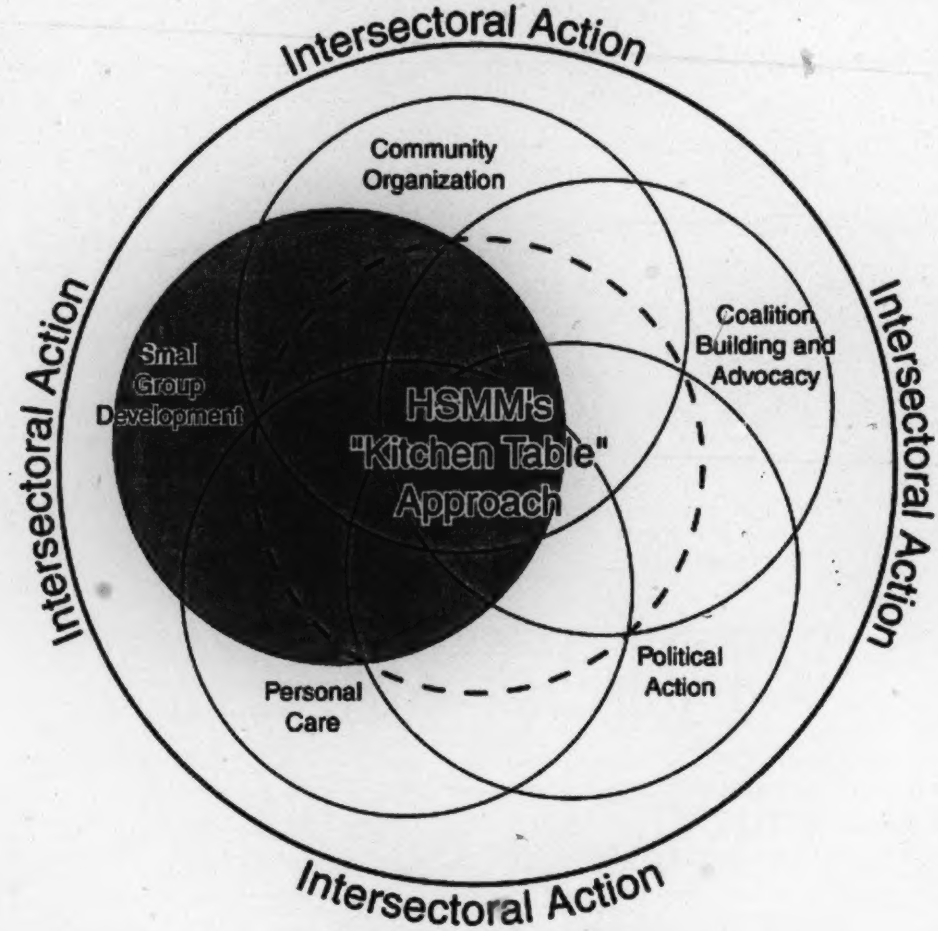

Intersectoral Action
Intersectoral Action
Intersectoral Action
Intersectoral Action
Community Organization
Coalition Building and Advocacy
Political Action
Personal Care
Smal Group Development
HSMM's "Kitchen Table" Approach

Figure 6.1: The Empowerment Holosphere in HSMM (small group development).

6.2.2. The Culture of Inequality

HSMM is engaged in the process of providing services to culturally diverse participants. When discussing the concept of cultural brokerage, in relationship to the role of the peer outreach worker, it is necessary to consider a broader definition of culture--one that includes poverty, in addition to the consideration of ethnic and/or racial differences. According to 1997-98 program statistics, 100% of HSMM participants described themselves as "low-income." The common culture of HSMM mothers, as described in Chapter 4, appears to be strongly related to their daily struggles in living in low-income situations. When conducting the focus group interviews at the Evergreen Community Centre and the Willow Community Centre sites, racial and/or ethnic differences between participants were raised in a positive sense only, suggesting that HSMM mothers welcomed the ethnic diversity that they experienced at the drop-in sessions.

When describing the culture of inequality, it is useful to consider the publications of Wilkinson (1999) on the topic of income inequality and health. Wilkinson maintained that the crucial determinants of population and health inequities in the developed world were "less a matter of medical care or the direct effects of exposure to hazardous material circumstances, as of the effects of the social environment as structured by social hierarchy" (p. 492). According to Wilkinson, low social status led to chronic anxiety and permanent increases in levels of stress-producing hormones, an increased incidence in cardiovascular disease, and compromised immunity. The outcomes, in many ways, are analogous to the process of accelerated aging (Sapolosky, 1994).

Wilkinson (2000) described the health effects of a general shift in the nature of social relations throughout contemporary society as

> not only lower levels of trust and more hostility and violence, but also lower levels of social support, weaker social networks and almost certainly more domestic conflict as well. There appears to be what we should probably call a 'culture of inequality' which is less supportive, more aggressive and macho. (p. 493)

This description of changing societal norms as a precursor to escalating social isolation, fragile support systems, and more domestic-violence is consistent with the changing social landscape described by HSMM program staff and community partners. Research findings presented in Chapter 4 suggest that marginalized women and their families living in the inner-city of Winnipeg daily experienced the "culture of inequality," as described by Wilkinson (2000). Therefore, the following discussion of cultural differences between participant women and professional service providers includes consideration of living in poverty and ethnic and/or racial differences.

6.2.3. Dealing With Diversity

The detailed description of HSMM's "Kitchen Table Approach" in Chapter 4 indicates that the program did not offer ethno-specific or parallel services for culturally diverse groups. Instead, HSMM delivered "multiculturalized" services adapted to low-income, isolated pregnant women, and teens. Rather than developing services that targeted specific ethnic groups, HSMM staff and community partners based programming on the identified needs of a cross-section of participant women. Community members' priorities spoke convincingly about the need to reduce the barriers associated with accessing neighbourhood-based, affordable, non-threatening, and culturally appropriate prenatal care.

The HSMM Collaborative Outreach Model (Appendix C) was founded on the vital role of the peer outreach worker in bridging the gap between professional staff and participant women. Additionally, interpreter services were contracted when necessary to assist staff and community partners in communicating with immigrant/refugee women, and hearing-impaired participants. In an effort to increase cross-cultural awareness, HSMM staff participated in cross-cultural workshops and in-service educational programs, read about other cultures, and experienced ethnic diversity through cultural events. HSMM resources were tested with groups of participant women to ensure that the health information was both linguistically and culturally relevant.

The ethic/racial mix of HSMM participants varied significantly according to the site. A brief description of the self-reported ethnicity of participants is important in proving a context for the description of the peer outreach worker's cultural brokerage role. HSMM program statistics indicated that in 1998-99, Aboriginal women represented 37% of participants (G. Wylie, personal communication, July 12, 2000). Certain HSMM sites had a higher representation of Aboriginal participants than did others. For example, the Evergreen Community Centre site consistently attracted a high percentage of Aboriginal participants. Direct observation of participants at the drop-in sessions suggested that the majority of the women and teens in attendance were Aboriginal, as were the mothers who participated in the focus group interview conducted at the Evergreen Community Centre site.

In 1997-98, immigrant and/or refugee women represented approximately 4% of all HSMM participants. Preliminary statistics for 1998-99 suggested that this number was increasing (G. Wylie, personal communication, July 12, 2000). Immigrant and/or refugee women frequented some HSMM sites more than other sites. For example, the Willow Community Centre site consistently attracted higher numbers of immigrant and refugee women as many lived in housing complexes, or apartments, close to the site. Direct observations of participants at the drop-in sessions revealed that close to half of the HSMM participants at the Willow Community Centre site did not speak English, nor did they understand the language. These participants were assisted by interpreters, often interpreting in more than one language. While conducting a focus group interview at the Willow Community Centre site, 7 of the 11 participants were immigrant and/or refugee. These women participated in the discussion with the assistance of two interpreters--one translating in Arabic, the other in Spanish. The phenomena related to the high numbers of immigrant and/or refugee women attending the Willow Community Centre site is discussed in Chapter 5 focusing on the experiences of participant women in HSMM.

6.3. Role of the Peer Outreach Worker

In addition to providing prenatal and postpartum support to women, the peer outreach workers engaged in community development and advocacy work in response to the struggles and life circumstances of HSMM participant women and their families. Peer staff members were an essential component of the HSMM program concept and operation. As many potential HSMM participants did not use, or were afraid of, traditional medical service providers, it was important to reach out to these women in alternative ways. The primary goal of the peer outreach workers' practices was to serve as a trusted bridge between professional staff and participant women.

HSMM documents indicated that the peer outreach workers were primarily involved with direct outreach and support to participants, and were considered to be "the main service-providers" in the program, under the supervision of the dietitian-coordinator (HSMM, 1996, Appendix 2). The peer outreach workers participated in the development of "care plans" and were responsible for following-up with HSMM mothers.

Additionally, they played a lead role in facilitating the operation of the community prenatal drop-in sessions.

Program documents submitted to Health Canada in 1998, listed "life experience" as a pre-requisite for the position of peer outreach worker. Additional competencies were "practical common sense, communication and problem-solving skills, sense of team work, demonstrated interest in health and well being, non-judgmental but sympathetic attitude, and willingness to learn on-the-job" (HSMM, 1998, Appendix B). A partial list of peer outreach worker responsibilities included these functions:

- Uses practical strategies to reach out to the target group--encourages target women to attend drop-in programs;
- Arranges transportation, or distributes bus tickets to drop-in sessions, as necessary;
- Prepares foods and assists in clean-up at drop-in sessions;
- Keeps files, notes, and records as directed by dietitian-coordinator;
- Ensures the appropriate use and distribution of resources and promotional material;
- Makes home visits;
- Participates in developing a prenatal plan with the participant and dietitian-coordinator or designate;
- Counsels/supports clients, refers as appropriate;
- Attends meetings and training events. (HSMM, 1998, Appendix B)

The original job description for the peer outreach workers, as shown above, does not appear to capture the advocacy role that the outreach workers played at the provider and institutional levels. Nor does the 1998 job description describe HSMM team initiatives to support collective action among participant women, and their families, and to address the inequities in health and social services and/or the lack of cultural responsiveness within bureaucratic systems.

The peer outreach workers' advocacy role apparently developed in response to program staff feeling increasingly comfortable and competent in their positions. Peer outreach workers described their cultural brokerage practices in individual interviews--they were obviously advocating for participant women within the HSMM program, as well as at other levels. Additionally, participant observation at the drop-in sessions revealed that the peer outreach workers were strong advocates for HSMM mothers, especially in the de-briefing sessions. Repeatedly, the peer outreach worker (Alice and

Diane) kept the team discussion focused on the needs of participant women and sensitively reminded team members to be vigilant in addressing barriers to the mothers' active participation in the program.

Recently, HSMM staff members used regular newsletters to support collective action among community-based partners, and participant women, in an effort to address health and social issues. An examination of past HSMM newsletters indicated that program staff very rarely used the Bulletin to advocate shifts in practices and policies at the institutional level. However, a recent Bulletin (July/August, 2000) included an invitation to readers to join HSMM staff, community partners, and HSMM mothers in the "World March Of Women 2000," held in Winnipeg, on September 17, 2000. The objective of The March was "to end poverty and violence in women's lives" by breaking the silence that surrounded the issue, and to draw attention to the growing problem of domestic abuse facing women in communities around the world.

6.4. Introducing HSMM's Peer Outreach Workers

HSMM's three peer outreach workers (Alice, Diane and Paula) were single mothers on social assistance at the time when they were accepted into a 10-month Peer Outreach Worker Training Course offered at Red River Community College. The pilot program was funded by "Taking Charge"--a provincial initiative that linked single mothers on social assistance to training opportunities and employment. The HSMM program manager (Sarah) and other members of the Steering Committee played an active role in the development, implementation, and evaluation of the training program. Considerable time and effort went into the design of the course curriculum to ensure that topics relevant to HSMM were covered in-depth. Sarah described the training that the peer outreach workers received and their unique contribution to the HSMM program:

> The peer outreach worker has 'been there, done that' and provides a sincere and trusted bridge to the program. Her training in nutrition and health basics, child development, community resources, helping skills, and food handling all converge effectively with personal experience. The outcome is that she has become a valued resource for both the participants and her team. This role, as well as the practical milk coupons, has been critical to the immediate quality and success of the program. (ONE Bulletin, 1998, p. 6)

Paula, a peer outreach worker, discussed how her initial involvement as a community representative on the HSMM Steering Committee led to her successful completion of the Peer Outreach Worker Training Program, and to her present position with HSMM:

> *I first became involved with Healthy Start, when it was in the developing stages, as a member of the Steering Committee. Sarah asked me to come to a meeting and participate as a community member. From that, I joined the Peer Outreach Training Program, completed the course, and was hired, actually while I was taking the course, as a peer outreach worker for Healthy Start.*
>
> *As a member of the Steering Committee, I felt for the first time that I had something important to share with people. I felt like my challenges as a young, single, mother had made me a stronger and wiser young woman. I felt valued.*

In response to a question asking Paula to describe her community-based volunteer experience prior to enrolling in the Peer Outreach Worker Training Program, she replied:

> *I was, I guess, in the community. I was a volunteer with a program called 'Equal Start,' which was a mentorship program for young single parents. So, I was a mentor, and matched up with a few women in the community, just being a support to them, and on the phone. I was a stay-at-home mom with my daughter. I was nineteen and my daughter was a year-and-a-half at the time I became a volunteer with 'Equal Start.' That's how my name came up. Sarah heard about the program and that's how she found me. I was asked to come to a meeting, and it just went from there.*

Paula was asked how she explained HSMM to family members or friends who may not be familiar with the program. In her response, she alluded to the infamous reputation of a north-end neighbourhood where she worked. Paula felt that it was important to address the "stigmas" associated with the community and she balanced the negative attributes with the positive characteristics of the area, and its residents. In the second quotation, her comments are consistent with those of McKnight (1997) who stated that lower income urban neighbourhoods are noted for their deficiencies and needs. Paula recognized the importance of identifying capacities and assets, both individually and organizationally, as a first step towards community regeneration:

> *What is HSMM? Five hundred-and-sixty pregnant women in six months! It's a city-wide program, and I work in these different neighbourhoods. I'd definitely describe the north-end, because for me and my friends, that's not an area that we've grown up in. It has a lot of stigmas on it.For example— 'It's just a nasty neighbourhood. Everyone there is totally tough.'*

> *I'd say, that it is a tough neighbourhood, there are those things. But, man, are there ever some* *wonderful* *things about that neighbourhood as well. It has so many strengths and so many strong people. So, I guess in describing Healthy Start, I'd definitely talk about the communities that it serves. That it is city-wide as much as we can be; and the milk, that we're able to offer the milk and why we offer it.*
>
> *That it's also a* *national* *program, because for me that's a big thing as well. That our government cares about pregnant women, because you don't often hear that. At least, my friends don't hear about it from what I can tell. Because it's not hot news in the paper, or on TV; it's not like this huge, huge issue. And, so I tell them that there are positive things happening--that there are commitments at the national level.*

Paula recalled her passion to become a peer outreach worker with HSMM and the overwhelming joy that she experienced on learning that she had been accepted into the training program:

> *When I applied for the Peer Outreach Worker Training Course, I had so much confidence in my abilities. I knew this was the field for me--that my skills would help improve me and my daughter's situation . . . . I could get off welfare and provide financially for my family. When Nan phoned me to offer me a position as a peer outreach worker with Healthy Start, I remember I cried with joy. I jumped up and down all over my apartment. I really felt like I had accomplished something. I saw what I wanted, I worked my ass off, and I succeeded!*

She described the training program emphasizing how the "well rounded" curriculum and practicum experience assisted in preparing her for the role of a peer outreach worker with HSMM:

> *It was a ten-month program offered through Red River* [Community College] *where we had full-time classes from September to December. Then there was a practicum from January to June, with school one day a week during that time as well. It was such a well-rounded program. Who ever developed the program did everything to try and give us as much information as they could, and in as many different areas as possible. Not just seeing it as, oh, dealing with family-abuse issues. It was everything, from community kitchens to prenatal nutrition, to reproductive health, to child development--this, that, everything! The training helped me in understanding my role better. When I go in* [to the mom's home or to the drop-in session] *it's* *not* *ever really offering the answers to things, but it's being able to identify and being able to assess situations: What could this woman use right now? What kind of information does she want? So, that I'm able to go to the right place to help her. That's what I think the training did for me--it gave me the information and the knowledge to be able to identify these different things.*

In response to a question asking Paula how she described her job as a HSMM peer outreach worker to friends, unfamiliar with the program, she stated proudly:

> *I tell them that I do everything and anything! I do group work, I do home visiting, I advocate on behalf of women, I do presentations, I help develop resources, I go to tons of meetings, I go for training, I do conferencing. It's a very well-rounded job, and I'm still learning every day. I feel more confident in my job, and I think I'm more competent now, and I can offer more to women now than I could have two or three years ago.*

Diane, the peer outreach worker assigned to the Willow Community Centre site, described her experience acquired prior to enrolling in the 10-month training program at Red River Community College: *"Before I started the Peer Outreach Training Course, I had just finished doing a peer-counseling training program at the Fort Garry Women's Centre and I was volunteering there. And looking after my two children."* When asked how she described HSMM, and its many components to a potential participant, Diane emphasized the community-based nature of the program:

> *I always start by telling them* [the mothers] *that it is a prenatal program and that it's totally in the community. It's not in an office, because they usually ask, 'Where is the office?' I tell them that we do have a home base, but the unique thing is that it's right in the community--it's not in a medical place. It's usually in a community centre, or hall, a church, whatever. I tell them that we bring the information to them, and the snack, and everything. I say, 'This is our phone number, and this is what you can get, this and that, kind of thing.' And I think by doing that, it breaks down barriers, right there. For me, if I were a participant, I would feel that someone's interested in really letting me know what's going on.*

At this point in our conversation, Diane recalled her first HSMM drop-in session and she told the following story describing her experience:

> *I remember our first drop-in. We had one mom come, and she was fifteen years old. She came with her mom and they came in and sat down. They were looking around, both had their jackets on, and so we had cheese and crackers that day, and juice, I think. We brought out the snack and set it on the table, and we just sat around because there were actually more staff than there were participants.*
>
> *So, we just kind of sat around and chatted. We were doing a craft, making some kind of bunnies, or something; I can't remember exactly. So, we were just sitting around doing that when they* [teen and her mother] *walked in, and so they sat down. But, by the time they were going to leave, we had talked about nutrition, about what was in the snack that day, and about how important it was to have milk and cheese and those kinds of things. So, it was very, very casual. And we had given her a binder* [of prenatal information] *when she left. By the time they*

> *left, they had their jackets off. At first, they didn't want to take any of the snack or anything, but at the end they were drinking juice and having some snacks. I think that they had seen that it was a really safe place to come to and that they were getting information, but that they weren't being lectured. That it was more of a sharing thing than it was anything else. So, she was excited. She wanted to know when the next drop-in was and she came back. And then, of course, we had more moms the next time. More and more and more.*

Diane's story reflected HSMM's emphasis on adult education principles and the importance of starting with "what the moms wanted to know" versus "what they needed to know" (Brookfield, 1986). Additionally, Diane stressed the significance of creating a safe, comfortable, and non-threatening environment at the drop-in sessions.

Alice, a peer outreach worker on the Evergreen Community Centre team, described her personal circumstances prior to enrolling in the training course: *"I was a mom just at home. I had a four-year-old boy and a one-year-old daughter. Actually, she was two, and my son was five when I started the Red River Community College Peer Outreach Training Course."* She proceeded to explain how she transitioned from a student in the training course to a full-time employee with HSMM: *"The program was finished in June and I was hired in July and worked 'point-eight', so I worked Monday to Thursday and had Fridays off. And then in October, I was hired full-time."*

Alice was asked how she introduced herself, and the role of a peer outreach worker, to HSMM participant women at a drop-in session:

> *I mostly do it on a one-to-one. And moms will come up or even if I'm on the phone this happens a lot when they're a new referral, and they'll say, 'What is a peer?' I don't know if I really feel comfortable telling them a whole lot about myself at that point, so I usually say, 'It's just somebody who's kind of been there, been a single parent, been on welfare, just like a peer,' and kind of explain what that is. And then the outreach part, 'Just to help you get connected to the community, help you get connected to different services' or whatever.*

Alice discussed the significance of her training in preparing her for the role of a peer outreach worker with HSMM. However, she conveyed the idea that personality was also a key factor, especially the worker's ability to observe and to listen:

> *I took a course at Red River, so I had that good background behind me, but there's still so much to learn. And, sometimes I think that you almost have to have that personality. I think that you have to be a certain type of person that can just connect with moms. It's not really easy to do, I find. For me, it comes naturally.*

> *I'm just myself; I don't try to be anybody else. I guess you could learn on the job, but it might take a while. You have to really observe . . . and I think that the training would really help.*

As our conversation progressed, Alice thought about the various program components and she told a personal story to illustrate, in a very powerful way, the importance of outreach and the role of the peer staff in attracting women to the drop-in sessions:

> *I guess the outreach is a vitally important of Healthy Start; just being out in the community. I remember a lady trying to get me to come to a group, she asked me, and then she asked me again, and again. Finally, I said, 'Yes, I'll come.' This was after I had my daughter Sarah. It was a Parenting Group, with other moms, at the Family Community Centre. And the same lady had asked me the year before; she had asked me a couple of times to come there, and I kind of went, 'Yes, I'll go,' but I never went.*
>
> *And then the next year I went back to see her again, and she asked me again, and she asked me every time I went to see her, and I told her, 'Oh, I'll just go,' but I had no intention of going. So finally she said, 'Listen Alice, I really want you to go. I want you to check it out and sort of see what it's like.' Then, she said, 'What I'll do is, I'll meet you there at say, one o'clock, and I'll bring you and introduce you and everything.' So, I knew that she would meet me there; otherwise I know I would have never gone, because she'd asked me to go for over a year. So, she met me there and just sat with me, introduced me to everybody, gave me a tour of the Centre. She sat there with me for the first half of it; then she had to go. And, then after that I just started going every time.*
>
> *My main reason for getting involved at the Family Community Centre was for my kids; it wasn't really for myself at that point. My son was going to be starting school soon, and he hadn't really been around other kids. So that what was made me go. Otherwise, I don't think I would have continued to go for myself, but just having my kids and knowing that I had to do it for them.*

Alice brought the conversation back to focus on "the lady" that she had encountered at the Family Community Centre and her persistence in encouraging Alice to join the Parenting Group. As the story continued, it became clear that this same individual was responsible for encouraging Alice to gain volunteer experience in the community. This experience was largely responsible for Alice's successful application to the Peer Outreach Worker Training Course that eventually led to her present position with HSMM:

> *And then this same lady that got me to go to the Parenting Group asked me if I'd be interested in being a volunteer for the 'Equal Start' program. So, I had been going to the Family Community Centre for about a year, and I kind of went, 'Oh, I don't know.' But, I went for an interview anyway. I did want to get off social assistance. I was at that point in my life, my kids were getting older, I needed to show them. I just knew that this wasn't the life for me. So, I thought, volunteering might be okay. So, I started doing that, and I did it for about a year.*
>
> *And then I heard about the training program, and I applied. And even applying for the program, the deadline was a Wednesday afternoon at four, and I got my application in about five to four, and that was with a lot of prompting from one of my friends that came to the program.*

Alice concluded her story by sharing what she hoped to achieve in her present position as a peer outreach worker. She suggested that in "nudging" HSMM mothers to take positive steps towards improving their lives, she demonstrated the kind of support to participant women that "the lady" at the Family Community Centre had extended to her:

> *That's what I do for moms in the program. I can just pick up on the girls that don't really want to be here, and just being able to go over and sit with her and just helping make her feel comfortable, and just giving them the extra nudges that you need and sort of pats on the back that you need to sort of move on, and grow.*
>
> *So, I guess I see my role as being that sort of person, just kind of how that lady at the Family Community Centre gave me that nudge and helped me, because I know if it wasn't for her, if she wouldn't have come to the drop-in with me, I wouldn't have gone; I know that I wouldn't have gone.*

Alice stated that one of the rewards of her work was observing the HSMM mothers developing relationships with the other members of the team. She concluded that the participant women, in all likelihood, would not have had access to either the public health nurse or the dietitian had it not been for HSMM:

> *And just seeing the moms connect with the public health nurses. Because in my own experience, I didn't know what a public health nurse did and what a vital role they play in the community. And connecting with a dietitian, because when you get weighed at your doctor's office, you don't get to ask questions, you don't have time, or you don't feel comfortable to ask questions. At the drop-in the moms can go and talk to the dietitian about what they've eaten and how much weight they've gained. It's just a good time to connect with these moms when they're pregnant. it's really rewarding when they come back with their babies. To see the healthy little babies and just seeing the moms, how proud they are.*

In summary, Paula, Diane, and Alice's personal stories shared common threads that reflected the key constructs of individual empowerment described by Wallerstein (1992) and illustrated in Figure 2.4 (Powerlessness and Empowerment).

6.5. Grounding the Team

Mary, interviewed as a key informant, spoke at length about the role of the peer outreach worker in HSMM. Her relationship with both Paula and Alice had developed prior to their involvement in the Peer Outreach Worker Training Program. She had observed the two teens making the transition from single mothers on social assistance, to competent community volunteers, to full-time students at a local community college, and finally, to highly valued and respected members of HSMM's core staff. Mary described the critical role of the peer outreach workers in *"grounding"* the HSMM team and the importance of their home visitation program:

> *They are so important. I think they ground the team; I think they keep it real. The peer outreach worker is like the mom who's 'been there, done that' kind of thing, so moms relate really well with them. They do a lot of counseling, but not in counseling terms; in listening, in helping. They're comfortable--they're welcoming. They're real; they're so real, and the moms really like having them around. And they also go out on home visits, and that's very, very important. Especially for a mom that's very shy, if she has somebody there that she's comfortable with, she'll come to the group.*

Researchers concur that home visiting provides excellent opportunities for personal empowerment (Reutter, 2000; Zerwekh, 1991) and has health benefits, particularly for families with limited resources (Ciliska et al., 1994). Recognizing this fact, representatives at the National Forum on Health (1997) advocated home-visiting programs for at-risk families.

Mary discussed the importance of the team planning meetings and re-enforced the peer outreach workers' contribution to the process. In the second quotation, she focused on the role of the peer outreach worker in leading the de-briefing meetings that took place following the bi-weekly drop-in sessions:

> *We do group planning for the drop-in sessions. And we've begun to do planning for two or three months in advance. We talk over the issues; we talk about the messages we want to give. What seems to have worked? What doesn't? Nurturing*

> *the team is really important. It doesn't just happen. You can really tell when the team is starting to pull together. During the planning meetings, we* [HSMM core staff] *make little suggestions for improvements, or we hear what the concerns might be about what happened.*
>
> *On my site, I have the peer outreach worker lead the de-briefing session. She has a form that we use and she sticks pretty closely to the form. I'm not a 'form person,' so I couldn't stick to that form; I'd be all over the place. But they* [peer outreach workers] *need that form, and they use it. And we've worked on it; we keep upgrading it or changing it a bit. And that collects information as well, so we can look back last year and see what's happened around a certain thing.*

In response to a question asking Mary whether the peer outreach workers were intimidated by the idea of "judging" the performance of professional staff at the drop-in sessions, she replied:

> *Oh, we don't do that, though. No, it doesn't come across that way. We may in private.* [laughs]. *But, during the de-brief time, they'll say, 'So, how was drop-in today? What was the atmosphere like?'*
> Interviewer: *The peer outreach worker don't say that something didn't work at the drop-in session?*
> Mary: *It's interesting, it kind of gets out, but gently, very, very gently. For my part, I might drop in and say, 'I really love the way you got the moms to talk today'--to focus on what I liked. We focus more on what we liked. Besides, what didn't work is generally so obvious.*

When describing her role at the de-briefing session, Alice validated Mary's comments that providing constructive feedback to professional staff was no longer intimidating for the peer staff. Alice stated that team members tended to respond to the suggestions positively because they were framed within a context of "what was best for moms":

> *I think they respond to the suggestions really well, because everybody has had to grow. It was all new in the beginning. I think just even the nurses working closely with the dietitians. And, there were never any outreach workers before, so that's all new. I think everybody's really grown and come back together for the same purpose, for the moms. And I always try to bring it back saying, 'It's for the moms--the moms are still coming so we're doing something right!'*

Beth, the HSMM dietitian and supervisor of the three peer outreach workers, reiterated Mary's idea that Alice, Paula and Diane "grounded" the HSMM team. She stated that by sharing their experiences, the peer outreach workers assisted other team members in gaining a more realistic impression of life as a teenage, low-income single mother:

> *I think that having that involvement was really important, and really seeing from their perspective what life was like, because I was never a teenage mom. I had no idea what it was like. You read books, or you see stories in the news, but you never really know what's it's like.*

In response to a probing question asking Beth what, in her opinion, contributed to the HSMM peer outreach workers' successes in connecting with participant women, she replied:

> *I don't know. They* [peer outreach workers] *are amazing women; they really are. As their supervisor, I don't think a lot of people can say as many good things as I can say about the staff that I have. I think that I've been very, very fortunate. They're sensitive; they truly, honestly, keep the participant women in mind. Every time we have a planning meeting, every time we are coming to a decision about, 'How should we deal with this situation with this particular woman?' they give us that perspective that I'm not sure we would have otherwise. And not only that--they're able to talk to women and women really trust them. That might not necessarily be right at the beginning, but they're able to gain that trust.*
>
> *Whatever magic they have, they do. And I think that they've taught everyone a good lesson--that you don't have to be ' in someone's face' to be effective. People will come to you once they trust you, and they have demonstrated that. Alice* [HSMM peer outreach worker] *has demonstrated that over and over again with so many women in our program. Alice is not the one to be kind of out there--outgoing. In our drop-ins she's very calm, but she's really able to connect with women one-on-one.*
>
> *I think that all of our outreach workers are really good in the sense that if they see women at our drop-ins that just really looks kind of lonely or shy or whatever, they are able to recognize that quicker than everyone else is, go up to them, and make them feel a part of the drop-in.*

In the above series of quotations, Beth alluded to professional staff learning from peer outreach workers how to effectively communicate with participant women without *"being in their face."* This learning, a fundamental "piece" of HSMM's "Kitchen Table" approach is described in greater depth in Chapter 4.

Diane described the early days of HSMM team formation. She suggested that initially the professional staff were ambivalent towards the role of the peer outreach worker. Diane discussed how this changed over time as the peer outreach workers consistently demonstrated their ability to connect with participant women:

> *I think that at the beginning our involvement on the team was so brand new that, I don't know, I always felt that it was, 'What is really her role in this?' sort of thing. Which now, I think has really changed. The nurses and dietitians really know, okay, this is what we do. I think that they have more confidence in us now.*
>
> *What helped with this? I think just by having a de-briefing after each drop-in, so we sit down, and if someone tells the nurse something's happening, she'll say, 'I think she needs this to be done,' whereas in the beginning it was more or less the nurses saying, 'We'll do the home visits . . . we'll follow up on this.' I think the nurses realized that the connections that we* [peer outreach workers] *were making with the moms was a* ***different*** *kind of connection than they were making. I think just the fact that the women opened up with us--they shared with us. Some of the stuff that they* [participant women] *shared was quite personal, and it would be on the home visits that it came out. So, I think that's where they* [the nurses] *started to see that. I would call it respect, because I think it was something that we had to earn.*
>
> *I think the same with the dietitians, because we're not as trained as they are about nutrition and stuff. We had some information at school, but there's no way we could have gone into talking about how important folic acid was, really. So again, it was the same as with the nurses. I think that the dietitians really saw that, okay, if I want this mom to get the idea that maybe she should introduce this* [food] *more into her diet, it* [the message] *sort of came through us.*

At this point in the conversation, Diane told a story to illustrate why the HSMM moms initially were fearful of the professional team members--in this example, the public health nurse--and how the peer outreach worker assisted in the trust-building process:

> *I remember taking a mom home from a drop-in one day, and she had some trouble with child care, and I said, 'I'll talk to* _____ [a nurse] *about that.' And the mom kind of hesitated . . . . I said, 'She* [the nurse] *has got connections with this Centre' and I said, 'I'm sure that she'll have some results for you.' So, I connected with the same mom at the next drop-in. When I was bringing her home she said, 'I was so scared of nurses because I thought that they were there to take the children away from me.' But she said, 'The nurse that you suggested phoned, and I got child care within the end of the week. So, now when I go into the hospital, that's set up for me.' And, the mom said, 'Just seeing the nurse in the kitchen washing dishes I think really helped me to see that she wasn't only a nurse, that she was a woman, so there was nothing to be afraid of.' So, I think that's one of the really interesting parts--that there is no way I think if someone walked into a drop-in that they could tell who's who.*

Diane's observed that the "blurring" of professional boundaries at the drop-in sessions was facilitated by the nurses assisting with food preparation and clean-up tasks, and the team deliberately dressing casually to blend in as much as possible with participant women. This phenomenon is addressed in greater detail in Chapter 4 on the "Kitchen Table Approach."

6.6. Connecting With Women

Brenda, a public health nurse on the Willow Community Centre team, spoke at length about the peer outreach workers' contributions to the program--specifically the strength of their connection to participant women. When speaking of the importance of shared life experience, she cautioned that peer staff must have reached the stage in their personal growth and development where they have "got it together" sufficiently to separate their issues, from those of the participant women. Brenda alluded to the steps that were sometimes necessary to achieve this degree of clarity and self-understanding:

> *The peer outreach workers have tremendous insight into what's going on in the personal lives of the women here. So, they make a great contribution as to what the needs of that person really are. They've 'walked the talk,' and maybe still are. They have a lot of empathy for the moms. They're mature women, and I'm not so much talking about age. And, they're ready to share; they've come to that point, so that they really do a lot of good. They are very perceptive and pick out the needs of that participant woman and they kind of work with it.*
>
> *I think that their training helped, but I think it also has a great deal to do with the person. Even though there is a lot of learning, and a lot of teaching, and all that kind of stuff, you really do have to hire a person who has it fairly well together. Fairly well together, meaning that they have gone through a lot of difficulties, a lot of dysfunction at a point in their lives, but yet have managed through self-help groups, programs--they have done a lot of learning and healing. I'm not saying completely, but certainly a lot of healing, that they come to the point now where they really feel that they can start to share and they can understand an awful lot more because they've gone through it. They know the needs of a person because they've been there; they know what it's like.*

In response to a question asking Mary whether the peer outreach workers conducted home visits with HSMM participant women between the bi-weekly drop-in sessions, she replied:

> *Yes, they* [peer outreach workers] *are doing home visits. It could be to follow-up on something that came up during the drop-in session, or something that they couldn't deal with in the group, or it could be to meet a new mom and get to know her a little bit because she's too shy to come to drop-in, so that she* [peer outreach worker] *can be a link between the group and the mom.*

Paula discussed the importance of the home visits to participant women and she described how the peer outreach worker decided that a home visit was indicated:

> *I know when I'm doing home visits, I can tell already, doing this for three years, I think I'm able to read body language very well, and to read how appreciative a woman is for me to be coming to her house. They're very shocked that that's something that we do as well, that that's something that we offer. We don't do home visits with every single woman in our program, but when a woman asks or requests a visit, we go.*
>
> *Or we offer a home visit in certain situations--we can tell they're having a difficult time getting out, or we haven't seen them in a while, we offer it to them. They're very, very grateful to have that visit: 'Oh, you do that? Oh, you'd come out? You'd come to see me?' And, when the visit is over, it's, 'Oh, thank you so much for coming out. Thanks, thanks.'*

During Beth's interview, she raised the idea that the peer outreach workers served as very visible role models for participant women. In the second quotation, she confirmed that HSMM mothers have occasionally expressed interest in knowing more about the steps that the peer outreach workers took to obtain their present positions:

> *I think that what Paula, Alice and Diane have done is tangible. I think it's something that other women feel that they can achieve, eventually. And they* [HMM peer outreach workers] *have been there, they have been a single mom, they know what that's like, and they were able to complete a training course. Now, they have a full-time job, a car, and all of those things that all of us want. I think that their training and what they do is tangible, and I think other women can relate to that.*
>
> *We've had a number of women that have come and asked the peer staff, 'How did you do it? Tell me the steps that you've taken to get where you are.' And, we have women right now who are following those same steps to become, hopefully, a peer outreach worker one day.*

Nan, a key informant who served as Beth's predecessor at HSMM, also suggested that the peer outreach workers functioned as role models in the communities that they served and that they were a valuable resource to women contemplating returning to school as a single mother:

> *They* [Paula, Alice, and Diane] *were a huge encouragement to moms and they became a great resource for other women considering resuming their education. They set an example. One of the peer outreach workers had taken her Grade 12 equivalent, or whatever, so they were encouraging others. There was a value placed on education that might not have been shared before, or that was being nudged along. You saw the the peer outreach workers help participant women cross thresholds where they were scared to go.*

During Alice's interview, she indicated that she was profoundly aware of being a role model to participant women and described her experience in coming to terms with this fact:

> *I just love connecting with moms, because I sort of see myself in some of the moms, and just to be a role model and show them that, 'Your life doesn't end here. You're pregnant; you've got kids and stuff; but you just keep on growing--it's not going to be the end.'*
>
> *I find that a lot of moms just watch me, and at first I found that kind of unnerving, because I'd come to the drop-in and I was self-conscious and I wasn't sure of myself either. I'm used to it now, but still, I'll be doing my thing in drop-in, and you can just feel, they just stare at you; they just watch you . . . . I think that's because some moms you can't connect with. You meet them, you talk to them on the phone, but you know there's sort of a wall there. You'll be busy at the drop-in and you'll feel eyes on you, and you know that they're just checking you out. Then, it will just click--all of a sudden--a girl will come up to me and just open up, and you feel that connection. That's really a nice feeling.*
>
> *At first I kind of thought, maybe I have to be going over there--really trying to connect with her. But, I've learned over the past couple of years that you just sort of do your thing, just keep in touch with them and, when they're ready, they'll approach you.*

At this point in our conversation, Alice came back to the idea of her giving HSMM mothers hope that their lives could improve. She cited an inspirational "success story" that gave her a great deal of personal satisfaction:

> *I was coming out of the ______ Centre one day, I heard some girl say, 'Hi Alice,' and I looked around; I didn't know where it was coming from. I saw this group of girls, and I know that there's a nursing college upstairs. I saw a group of girls, and I didn't recognize anybody, and she was like, 'Hi Alice!' She got up and came over to me. Here it was one of my moms from the ______ Centre. She's taking a nursing course now. And she said, 'I've learned so much in Healthy Start, I teach my teachers stuff on what I've learned, and this course is very easy for me.' It's such a nice feeling to see them on a different path. They come to drop-in pregnant, like I said before, it's sometimes so hard for them to know that there is a life out there.*

Anna, a public health nurse on the Willow Community Centre team described Diane's ability to connect with participant women and her impressive record in attracting women to the HSMM site. She maintained that the nurses did not generally have the time to invest "up front" in developing the relationships necessary to bring women to the site:

> *Diane has been there. She's having to raise her children on her own, so she knows, and I think women realize that. I think she makes good connections. She was always successful in bringing women to the program. I wish she had more time to go and talk to women, to find them, and bring them in, because I think that part is important. It has really brought women into the program.*
>
> *To be able to really get someone into the program, you have to establish a connection. You have to in some way make it easy, make it feel comfortable to the woman to come. And, if you're just talking to them and they don't know you, they don't trust you, they're not coming. That's what Diane does all the time; she connects. She phones them back, and she will give them a ride to the drop-in that first time.*

In the interview, Paula described how much HSMM meant to participant women, and how she had gradually come to see the role of the peer outreach worker as a critical component of the program. The following series of quotes suggested that program staff initially under estimated the social isolation that participant women experienced on a daily basis. Paula reinforced the importance of regular phone calls from peer staff in breaking that isolation and demonstrating to HSMM mothers that team members *"really did care"*:

> *On a day-to-day basis it's sometimes hard to remember how much we have, how much our programs are out there in the communities, how much our program does mean to women. And then when the comments come in, it's just a shock time and time again, because we forget, I think, how much of an influence we have had on the women and how important we have become in their lives as a place to break the isolation.*
>
> *I think that the biggest thing that I've heard from women, is 'HSMM gets me out of the house. It's a place that I can come to and I've met other people.' I'm really hearing that they* [participant women] *see us a support, as part of their support in their lives. When you make phone calls, you can hear how happy they are to hear from you. You can just tell that your phone calls are welcome. We contact every woman in our program by phone, if they have a phone. At least once ever two weeks we make that attempt. So, we really try on a regular basis to connect with each woman to let her know that we care about her, and that we're still here. I think that's had a big influence on them. They know that there's someone out there, that they don't just sign up for a program and if they come, great; if they don't--oh well. I think that they've noticed that we care.*

Alice concurred with Paula that the phone contact between peer outreach workers and participant women was very important in building and enhancing relationships:

> *I get a lot of calls from girls that have missed drop-in, because they got my phone message, or they know they've missed sessions. They phone and tell me what's going on with them, what was going on the last two weeks, why they couldn't make it--just connecting with me to let me know what's been going on in their lives.*

Diane, like Paula, identified the issue of social isolation that HSMM mothers experienced and the role of HSMM in breaking that isolation and building friendships among participant women. The peer outreach workers' comments on the role of HSMM in reducing the social isolation of participant women are consistent with the constructs of social support (Stewart 1990a, 2000) and the conceptual model illustrated in Figure 2.5 (Nursing education conceptual model based on social support).

> *I think some of the moms that come are very isolated. HSMM is a place to come to. They feel comfortable coming; they're starting to make friends when they come to the drop-ins. Maybe, they're not listening so much to the information, they're coming more for friendship.*

When asked how she knew that the HSMM mothers were "making friends" at the drop-in, Diane explained that

> *They're coming in and going, 'Hi, how are you?' And, if someone's not there, usually someone asks about them. Maybe they don't even know the name of the person, but it's, 'What happened to the lady that was going to have twins?'*

Diane described the value of HSMM to participant women, citing an example of one mother's response to a resource binder that she had been given to take home:

> *We had given a binder to one of the moms and explained to her that this was hers to keep; she could keep it, and when she was finished with it, if she wanted to return it, then she could do that. And she came back the next time and had all these questions written down from the binder. She went through the binder and asked, 'I have a question on here and here and here.' So, she actually was taking home the information that was in the binder, reading it, thinking about it, and finding out that there wasn't enough information in there for her. She wanted to know more about vitamins or whatever, and so she asked for it.*

Focus group interviews with participant women at the Evergreen Community Centre and the Willow Community Centre suggested that other HSMM mothers responded positively to the information provided in the binder. Research findings described in Chapter 4 indicated that the provision of linguistically and culturally relevant health information strengthened the mothers' connection to HSMM.

Jane, a nursing member on the Evergreen Community Centre team, described how she introduced potential HSMM participants to the unfamiliar role of the peer outreach worker. The following quotation underscores the diverse range of responsibilities that the peer staff assumed in an effort to connect with participant women:

> *I just explain that they are women who can help them* [the mothers] *with a variety of different issues. So, 'If you're having difficulty accessing housing that's something that the peer outreach worker can help you with, whether it's driving you down to the housing office, or going to a meeting with you, or helping you with any paper work, or with CFS* [Child and Family Services] *or whatever . . . if you feel that you would like someone there to help advocate for you, then that's a role that they can play; or in helping you find other resources that might be appropriate.' So, that's usually how I've let them know how a peer outreach worker can be helpful for them.*

During Beth's interview, she expanded further on the multi-faceted role of the peer outreach worker. In the following quotation, she discussed a peer outreach worker's attempt to secure food for a "hungry" mother:

> *If she* [the HSMM mother] *doesn't have any money left, and she's hungry, I'll try to see if there's a way that I can connect her, say, for example to the food bank in her neighbourhood. Or, if one of the peer outreach workers knows the food bank in her neighbourhood, we've had the outreach workers take women to the food bank if they're going hungry, and they know that they can call us.*

Diane identified a "spin-off" activity in the community that developed in response to HSMM's presence in the community. She described her involvement in a successful community garden project and the HSMM mothers' delight in sharing in the harvest:

> *I know of quite a few spin-offs from Healthy Start that I think started, not necessarily because of Healthy Start, but because we were there. One of them was a community garden that started from one of the drop-ins. The moms took part, not actually doing any physical work, but we'd walk down to the garden together during the times that we had the drop-in.*
>
> *And then come harvest-time the moms, with some of the elderly volunteers, from the Centre took part in that too where they did the actual labor in the*

> *garden, going to weed it and looking after it. At harvest time, the moms were able to take home some of the vegetables.*

When describing her work as a peer outreach worker, Paula admitted that it was challenging and that she constantly strived to keep things in perspective. Paula described her work as a *"roller coaster ride"* meaning that she was constantly dealing with the unexpected and attempting to balance the "highs" and the "lows":

> *It's like a roller coaster ride. You have your hard days doing the work that I am trained to do, as a peer. Maybe, for some people it is difficult to understand--I'm not a social worker with women. When I go into their home, I am their peer, and I do everything in my power to keep it like that. And you see a lot of sad things; and sometimes it's hard to be always picking out the positive, because that's what you want to do* all of the time*. But leaving* [the homes] *sometimes, you definitely see a lot of sad things. That's why it's a roller coaster, because you'll have your great days where you could go into that same home, on a different day, and just think how beautiful her children are, what a beautiful woman she is, all this stuff, and look past the poverty, look past the abuse issues, and see how beautiful her children are. So, it's a roller coaster.*

She went on to explain that in comparison to other members of the HSMM team, the peer staff probably felt closest to participant women because they shared so many life experiences. In the following series of quotes, Paula described her fellow peer outreach workers as her "lifelines" and she stated emphatically that the three of them shared a very special bond:

> *I'm sure that I could go to school, and become a nurse, and go into that home just as any other nurse would. But, I would not feel the same way. Because I would have a different experience going into that home. I'd be going into that home as a nurse, but I'd be bringing my life experience into that as well.*
>
> *The hardships that these women face are just unbelievable, they really are. It's not fair. And that's the whole thing. You can really get caught up in that all, like, "What is going on here. What is going on?' My fellow peer outreach worker are just--really, I do have to say that they are part of my lifeline--the sharing, because they can identify with what I'm going through like no one else can.*

Paula discussed how she attempted to keep things in perspective, consciously focusing on the strengths of participant women and their astounding ability to survive, even when facing great personal challenges:

> *It's just recognizing that these women are making it. Someone could look at my life, maybe someone that's living in a mansion and going, 'Oh, my God. You drive a Dodge Sundance? How do you do that?' You just have to put things in perspective that these women have lots of strengths. It's just reminding yourself of that time and again, and they show you, they show you.*

In the conclusion of the interview, Paula emphasized why she "loved" her job, particularly the opportunity to connect with women and to share her expanding knowledge and experiences with them:

> *What I love about this job, is that I can go out and sort of share with them some of the information that I have, knowing the situation they are in. And I just like telling them all the stuff that I didn't know. Just making connections with a mom, that's really rewarding for me, because sometimes there'll be girls out there that don't trust anybody, and you know that they don't. Sometimes, it just 'clicks'--you connect with them and you can share that information. I guess I couldn't just go up to the mom and just tell her all this stuff--how important it is, or whatever. You could tell it but it would go in one ear and out the other. You have to have that connection with her--that comes first.*

6.7. Lessons Learned

Several of the interviewees discussed the importance of the Peer Outreach Worker Training Course in providing the HSMM peer staff with the requisite knowledge, skills, community contacts, and resources to competently perform their jobs. There was universal agreement among interviewees that the training program should be offered on an ongoing basis to acquire a "pool" of trained peer outreach workers. Program partners and key informants identified current and anticipated job opportunities for trained peer outreach workers in the Winnipeg community. Interviewees stated that re-instating the training course would help to establish needed performance standards for peer outreach workers.

Mary's "wish list" with respect to peer outreach worker training was very similar to that of other interviewees. She described the significant differences between the performances of peer outreach workers who had completed the training program and those who had not:

> *I wish that we could have the training course again. It makes such a difference--in the level of confidence, in the way the peer outreach worker knows what to expect, and in making sure that she has some skills to draw on. Working with high--I hate the term--but with high-risk moms is really specialized, and not everyone can do it. Peer outreach workers need training and they need experience. And the difference for the ones that had the training moving into those jobs . . . they could hit the ground running, and they also had a deep understanding of the issues. They knew the issues from the inside.*
>
> *It's different when you're talking to another mom, because you can't put your experience on to the mom; you have to be able to separate your experience from that of the mom. That's very hard to do without some kind of process, some kind of educational process.*

Sarah, the HSMM program manager, concurred with Mary and she emphasized that all of the original group of 30 peer outreach workers trained through the Red River Community College course were employed in meaningful positions in the community:

> *I was disappointed to find out that the training course was a one-time kind of thing. It is important to have this group of knowledgeable, trained peer outreach workers to draw on, because the original group has evaporated. They all have gotten jobs. Or, they've got committed into the community, which is great. There's one working in the new FAS program, and one in Youth Services and so on.*

When asked to describe "lessons learned," Anna, a public health nurse, spoke of the personal satisfaction she derived from "watching" Diane grow increasingly more confident in her peer support role. Anna also suggested that her way of working had changed as a result of her experience with HSMM. She now tended to be more team-oriented and more flexible in her approach:

> *The thing that I like a lot about HSMM, is not just the participant women, it's about this other woman--Diane. She's working as a peer outreach worker on my team. I have seen her growing, settling, and being more confident. I* ***really*** *like that. It make me feel as if the program is working for the peer outreach worker, just as it's working for the moms. And, I'm sure for us* [the professional team members] *as well.*
>
> *Maybe I don't even know how I've changed and what I've learned consciously, but we all do. So, it's teaching me to work with other kinds of professionals, and people, and to adjust. I think it has done that.*

Nan also described the learning that she had acquired from the peer outreach workers. She emphasized that the peer staff constantly challenged the professional staff to work together in new and innovative ways: "I think the peer outreach workers challenged all of us as health professionals to reconsider a lot of the ways that we'd approached our work in the past, and to carry it beyond." This finding is discussed further in Chapter 9 on "Interdisciplinary Collaboration" in HSMM.

Nan expressed her deep concern for Diane, Paula, and Alice and her constant worry that, given their work and home responsibilities, they carried a heavy load. She stressed the importance of building the capacity of HSMM participant women to assist them in assuming some of the roles and responsibilities of the peer outreach worker at the drop-in sessions:

> *I worry about the peer outreach workers. There's a lot of stuff we've placed on them. As much as I value them, they're still very modestly paid when you consider that they're parents of children, that they need a vehicle to do their job . . . . There's so few of them for the number of women in the program.*
>
> *If the peer outreach worker, who received nine months of training, can do this, what other capacity is there with those other mothers who come to us as participants? I think it is important not to just end it there, but to use the peer outreach worker to show other women that they too can make that move, because that's ultimately what our program should be all about.*
>
> *Now we're long enough into the program, that if we need more outreach workers, can we find them within the ranks of people that came as participants? Are there roles for those participants to play in supporting one another in breastfeeding and things like that? I think that we need to create in Healthy Start places where these women can get that kind of experience because it builds them up directly, it looks darned good on a resume, and they do get hired when they have that community experience and they can demonstrate their skills. So, we need to create a lot more roles I think for them to contribute because they're very capable of it.*
>
> *I think that I started to see,* in action, *the potential for supporting people, and how when they get support, their impression of themselves starts to shift in a positive direction. They begin to see themselves as capable people, rather than needy people. All of us are needy people, but we also have capacities and capabilities.*

Nan stated that she saw the HSMM peer outreach workers in a state of personal transition and she described their experience in HSMM as "empowering." She implied that one, perhaps two, of the peer outreach workers were contemplating returning to school for additional training:

> *I see the peer outreach workers in a transition period. This is such an empowering experience for them. A couple* [of the peer staff] *that I know very well, have identified this for themselves, and will one day go further--hopefully, to pursue a university education for the first time. I think they now realize they are*

> *very capable. HSMM impacted directly on the first determinant of their health, which was income. They started earning an income, sometimes for the first time in their lives. But, I think that the other thing that has impacted them tremendously, is education. I see a couple of them whose pregnancies totally stopped their education now coming to a position of strength, with increased self-esteem, where they're considering embarking on their formal education again.*

Diane discussed her "lessons learned" in a pragmatic manner, focusing on the knowledge she had acquired in the areas of nutrition and prenatal care. She expressed regret that she went through both of her pregnancies without "knowing anything":

> *What have I learned? Oh, everything, because I didn't know anything when I was pregnant with my two children. I never went to any classes; I just did what I basically though was okay . . . but if I'd had a program like this, for sure my children would have had a different start.*

After pausing to reflect, Diane expanded on what she had learned through her involvement in HSMM:

> *How has Healthy Start impacted on my life? It feels like I sort of grew up at Healthy Start. That I started being someone that had little information and little things that I could do . . . but now I've grown into not only giving information to people, but also receiving information myself and sort of placing that in my life and saying, 'Okay, this sounds good. Maybe, I'll try this.' One thing I hate is being given information and say, 'Okay, you have to tell this person that it's good to eat this or it's good to do this' or whatever. If, I don't do it myself, I don't feel comfortable giving that information to someone else.*

Later on in the interview, Diane told another story that demonstrated the impact of HSMM, not just on her, but on her entire family:

> *I remember we had done an interview on the radio when we first started the HSMM program, and my oldest daughter had said to one of our supervisors, 'My mom's going to be on the radio? I didn't know that she was that important!' So, it's seeing my children saying that my role is important and that what I do in my job is important.*
>
> *Last Thursday was 'Go to Work with Your Mom Day.' I think my daughter really enjoyed being here. She's been a couple of times at Healthy Start, volunteering, doing things. She knows how important Healthy Start is. She knows that, again, my being a single mom, a lot of times we were low on food and low on this, and that I didn't have that connection with my kids, that I didn't have someone to go and chat with or whatever. So, she sees that HSMM is very important for our family.*
>
> *And I know that she tells her friends that are pregnant, that are young, that there is this program now that can help them and stuff. I know we've had a*

> *few from the high school where she was. We've left posters and information at the school, and the guidance counselors know about the program. But my youngest daughter is like, 'Oh, yeah, my mom works for this* [program]. *Just go there, and they'll give you free milk if you need it.' So she knows all about milk coupons and she talks to the ladies if they have babies 'Oh, so you're drinking milk, are you?' So, she gives them the information. I think that they* [my daughters] *are both very skilled at talking with people, so I know when they decide on a profession that they will choose a profession that they can use it.*

Diane described the supportive environment at HSMM and the high degree of comfort that she experienced in her day-to-day work. She referred to HSMM as a "place for growing" and she contrasted the work environment with other offices where she had worked:

> *I think it's a place where not only the participants feel comfortable, but a place where the employees feel comfortable as well, because it's a place for growing. It's like, 'Yes, you made a mistake here,' but it's not looked at as, 'Gosh, you've done this wrong,' or 'The butter's burned' or whatever. It's a really comfortable place where it's sort of explained, 'Okay, maybe this is not working. Let's try this way instead.' So, it's a very healthy atmosphere all the way round. I think there's certain expectations, but there's no expectations that are so high that they're impossible to reach.*
>
> *I think it's just getting together and not saying, 'Okay, this is what should be done.' It's more of a collective thing. It's sharing. If someone's having difficulty, everyone sort of contributes to making that person feel comfortable, or giving them information if it's information that they need, or suggestions, or just saying, 'Hey, we're here if you need to talk or whatever. That's what we're here for.'*
>
> *It's a professional place to work, but it's not a rigid place to work, I think. Most of the other places where I've worked were like that. So, if your house burned down or whatever, who cares? I'm not saying that HSMM is a place where you bring all your problems, but I'm just saying, if something's affecting you, I think that the 'higher powers' at Healthy Start understand that it's important to deal with those things so you can do your job.*

During Paula's interview, she also spoke of the nurturing environment at HSMM where program staff were encouraged to take risks and were fully supported by management:

> *I have been so fortunate to be involved with such a nurturing group of people. They've seen in me* *not* *only my disadvantages, but my strengths. In this example, our whole program models this outlook in everything that we do. I rarely felt that my self-esteem took a beating, (and if it does it's usually self-inflicted). I feel like*

> *Healthy Start is a place to learn and grow. I love being the 'young'un' of Healthy Start, but I know I've grown and matured so much since I first became involved.*

Alice, like Diane, initially described her learning in the area of nutrition and prenatal care. The concept of a women preparing for pregnancy was new to her and she emphasized the importance of communicating this message to participant women:

> *I guess just how important it is, that it's a very important part of your life, and to take care of your self, do the best that you can. I think for me when I first was pregnant, it didn't seem real to me. I knew I was pregnant, but you couldn't imagine, your mind couldn't fathom that you'd have a baby, that there's be a baby at the end.*
>
> *I think just the fact that right from conception, even before that, it's important to have your folic acid before you want to conceive and stuff like that, and how important those things are. I think the thing that I learned is that it's* [pregnancy] *is something to prepare for, not to be surprised with--Oh-oh!*

She then proceeded to describe the changes that she observed in the mothers over the course of their involvement in the program. These changes are consistent with the variables of personal empowerment described by Wallerstein (1992) and discussed in Chapter 2.

> *You just know that they* [participant women] *are in a different position than they were when they first came to drop-in. They're just more confident; they know how to go about and get help if they need help; they know that there's people out there that actually care about them and that they can pick up the phone and call, and there's a connection with the community that wasn't there before.*

At this point in the interview, Alice contemplated "lessons learned" from a personal perspective and she spoke movingly about how much she had changed through her involvement with HSMM:

> *I guess it's sort of given me a lot more confidence in myself. I was really, really shy before. And I guess even when I go back home, my girl friends will say, 'You're so different. You're just so chatty.' Because, even just doing an interview like this, I would not normally have been able to do it. Even in class* [Red River Community College], *when I took the course, I was the quietest girl in the class; I would never say anything. So for me, even from going to class to where I am now--getting up in front of the moms and introducing myself--that took a long time for me to be comfortable doing that but now I just do it. I still struggle with having to do presentations and stuff, but they're getting easier too.*

Alice then reached deep inside herself to share her dreams and aspirations, in a very thoughtful and insightful manner:

> *I think I'm sort of finding me, who Alice is, and finding myself as an adult and contributing to society and raising my kids and being a good role model to them. I think I'm a different person. And I keep growing all the time just learning all about prenatal nutrition and all that kind of stuff. It's interesting, and it's sort of the field that I've always been interested in, so it's nice to feel confident that you can pass on information and help other women make differences in their lives.*

Judy, a community dietitian on the Willow Community Centre team, stated that her "lesson learned" related to the positive impact of the peer outreach workers on the program. She implied that their presence was highly visible in the community and that the peer outreach staff had achieved remarkable success in attracting moms to the drop-in sessions:

> *I don't think I've talked enough about the peer outreach component, and I think it's wonderful. It's really brought us not just Diane, but all of her connections with people. And, Diane, right from the start, was just the kind of person that will automatically make connections with others, no matter what their background was, what country they were from, people make connections with Diane, and that has been a real building block for the program. And part of it comes from their* [peer outreach workers] *special training, and part of it just comes from their hearts. They really understand what women are going through, and the insights that they provide to all of us is really a help and has made a difference.*
>
> *And, personally, they* [the peer outreach workers] *have struggled with all kinds of things as the program has developed in terms of looking after their own families, and moving, and working through financial crises and a huge number of things . . . going to the bank and getting a loan to buy a car. They've all been growing experiences, very traumatic, and they come through them with flying colors.*

Beth acknowledged that other Winnipeg-based community agencies and organizations had come to appreciate the value of peer outreach, as a direct result of their experience with HSMM. She reiterated Judy's thoughts, that the peer outreach workers were the "building blocks" on which the entire program was based. This idea will be discussed in greater detail in Chapter 7 focusing on the Community Organization "level" of The Empowerment Holosphere in HSMM (Figure 7.1):

> *I think the peer outreach is a very unique approach, and I think that it's really three people that have made such a difference. They have shown the community what a benefit and what a service they can provide to women--that it doesn't have*

> *to be a dietitian, or a nurse, going to see somebody. They can go out and visit somebody* [a client] *and talk about the eating disorder, and 'I know it's tough, but maybe you might be able to get help.' They can do it, too. And I think people have seen how valuable they are--how they've been able to help women in our program. Three people have done that, and that's amazing to be able to say that. And I think that, in itself, has made people more willing to hire peer outreach workers. So, I think that Healthy Start's success with peer outreach has helped other programs. That's for me one of the key things--if we didn't have the peer outreach workers, the program wouldn't be what it is today.*

After Paula had reviewed the transcript of her interview, she attached a note, excerpted below, to provide a more complete answer to the question that she had been asked on "lessons learned":

> *I was scared of working side-by-side with nurses and dietitians. I was scared of phoning welfare workers, doctor's offices, social workers . . . these people, would they respect my role? Would they see me as one of them? Sitting on a committee with professionals as a community volunteer, seemed to me a whole lot different than actually working with them. And how would the women participants see me?*
>
> *Because of all of these feelings, it was really hard to speak up at times when my role as a peer support warranted it. I needed to say when resources or methods weren't appropriate; how doing it differently might be more effective. Healthy Start was doing things differently, we were saying, we think this approach will work, but we don't know for sure. It took time for me to completely and whole-heartedly believe in my role. It took time for the team members, different agencies, and the community to believe in my role. But, I did have enough confidence and enough people behind me who did believe in our role that us outreach workers stood strong and proved how invaluable peer support workers (that we were trained) can be.*
>
> *Now, I feel that I can be more effective in my role, because of not only my experience, I've gained over the years, but because the same people, agencies, communities who may not have trusted us before, now know we're 'good' people.*

In the conclusion of her note, Paula chose to express her heartfelt thanks to HSMM and to all who had accompanied her on the personal journey described below:

> *I am so thankful that Healthy Start, and all the people I've come into contact with through Healthy Start, have been part of my journey. I have learned so much through my experiences here, and my learning and growing continues. I know I have touched others, and have been a part of others' journeys. What a gift to have given and received!*

I was thrilled to receive Paula's hand-written comments because they added a great deal of depth and meaning to our earlier recorded conversation. I was also touched that she had devoted so much time and energy to making sure that I understood her answers to the questions that I had raised during the interview.

6.8. Section 2–Theoretical Constructs

6.8.1 Small Group Development in HSMM

Health promotion theory tends to define the community as the “engine of health promotion--the vehicle of empowerment” (Labonte, 1994, p. 62). However, Labonte argued that a more accurate definition would suggest that the small group was, in reality, “the locus of change--the vehicle of emancipation” (p. 62). The research findings presented in Chapter 5 emphasized that HSMM participant women would have remained marginalized and uninvolved had programming efforts been targeted solely at the “level” of personal care. Through their ongoing involvement in the drop-in sessions, participants gained the health-enhancing characteristics essential to empowerment: control, capacity, coherence and connectedness (Wallerstein, 1992). Findings pertaining to HSMM’s “Kitchen Table” approach, dealt with in Chapter 4, indicated that the peer outreach workers’ interventions played a pivotal role in the development of the small group at the drop-in sessions. Strategies included transporting new participants to the site; ensuring that the physical space at the drop-in session was conducive to the group process; facilitating the “ice breaker” activity at the drop-in session; distributing milk coupons; maintaining contact with participants between sessions on an as-needed basis; and leading the de-briefing meeting with team members.

Labonte (1994) emphasized that the process of group-building takes time. He stated that “it often takes between one and two years before the first ‘group’ squiggle may form from the disconnected individual dots” (p. 63). At this point, individuals begin to self-identify as group members and the formation of the group “gels.” Within HSMM, the formation of small groups was time-limited because pregnancy, a condition for joining the group, was time-limited. Although women had the option of attending HSMM’s postnatal program, the maximum amount of time that a participant was involved in the prenatal program was nine months. It is unrealistic to think that the groups of women and teens attending the HSMM drop-in sessions could turn their collective attention to issues extrinsic to their own dynamics over a nine-month timeframe. Thus, programming interventions at the drop-in sessions were primarily directed towards the spheres of personal care and small group development. Interventions did not progress to the community organization and/or coalition building and advocacy "levels" of The Empowerment Holosphere in HSMM.

Researchers maintain that although the transition from small group development to community organization is challenging on many fronts, it is essential to achieving community social change. While improved self-esteem, social support, and self-help may be empowering experiences for individuals, positive outcomes within these spheres may mask political motivation to act on the broader socio-environmental determinants of health (e.g., income, education, and access to services). The findings presented in Section 1 of this chapter suggested that the peer outreach workers provided a bridge between the intra- and interpersonal aspects of social support (self-help, self-efficacy, self-esteem) and the community social change potential of social support (organizing, advocacy, healthy public policy). The community social change process in HSMM is discussed in Chapters 7 and 8.

6.9. Summary

This chapter focused on the role of HSMM's peer outreach workers in bridging the gap between professional staff and participant women. The gap was the result of "dual ethnocentrism"--the different cultural orientations that existed between service providers and their patient/clients (DeSantis, 1994). The "bridging" phenomenum proved to be a critical step in connecting the small group development and the community organization "levels" of The Empowerment Holosphere in HSMM (Figure 6.1).

Early in the chapter, it was necessary to broaden the traditional definition of culture, to include the experience of inequality. Program data and information collected in focus group interviews with participant women indicated that living in low-income situations was part of the common culture shared by HSMM moms. The peer outreach workers' practices of cultural brokerage were envisioned as a strategy to bridge the gap between the worldviews of professional staff and participant women.

As described in Chapter 7, HSMM team members interacted with the community as a whole using a community development approach. Program staff and community partners functioned as both facilitators and enablers in assisting community members to determine their needs and the best ways to meet those needs. Networking and the active involvement of HSMM participants in program planning, implementation, and evaluation, were steps within the community development process that helped identify community members' priorities. Consistent with Jezewski's 1995 definition of cultural brokering (p. 20), HSMM team members addressed inequities in health by providing linguistically and culturally relevant health education and information to participant women; by connecting women and their families with mainstream health and social services; and by advocating changes in practices and policies at the service-provider and institutional levels.

The research examined the factors that promoted or hindered the peer outreach workers' practices of cultural brokerage with marginalized women and their families. Findings confirmed that small groups were important vehicles for empowerment because they promoted connectedness. Within HSMM, groups decreased the social isolation often accompanying poverty by mobilizing and augmenting social networks. The drop-in sessions provided participant women with information as well as affirmational, emotional, and practical support. While support groups can increase the self-efficacy of members (Stewart, 1990b), "the bi-directional or reciprocal help that is the hallmark of self-help mutual aid groups may be particularly empowering" (Reutter, 2000, p. 185).

Racial and ethnic differences between participant women and program staff were addressed through the provision of "multiculturalized services" that recognized the need for special and/or adapted programs for culturally diverse groups and individuals. Bridging services were contracted by HSMM to assist program staff in communicating with participant women who were unable to speak, or understand English. Additionally, all HSMM resources were evaluated by participant women to ensure that the health information provided though the program was linguistically and culturally relevant. Findings underscored the importance of researchers employing culturally inherent paradigms and methods to ensure that community-based research involving ethnically diverse populations is of the highest caliber from an academic perspective.

HSMM program staff and community partners engaged in an ongoing process of developing cross-cultural awareness. Team members actively participated in cross-cultural workshops and in-service educational programs, read about other cultures, and experienced ethnic diversity through cultural events in the community. On occasion, and when appropriate, HSMM participants of diverse ethnic and racial origins, shared values, beliefs, customs, and ethnic foods with program staff and community partners. This phenomenon is described in detail in Chapter 4 on HSMM's "Kitchen Table" Approach.

A central observation related to the training of peer staff and the importance of the Peer Outreach Worker Training Course in preparing the three individuals for entry-level positions in the community. Interviewees strongly reinforced the need for ongoing training, performance standards, and a "pool" of trained and knowledgeable peer outreach workers. The practicum experience was considered to an essential component of the formal training that the three HSMM peer staff received at Red River Community College.

Several interviewees felt that it was critical for managers to appreciate fully the time, energy, and flexibility necessary to coach the peer outreach workers in their day-to-day work. Additionally, it was important to recognize that the peer staff tended to have complex and stressful lives and it was not always easy for them to keep their professional and personal lives in balance. As one interviewee perceptively pointed out, "in some situations there may be only 10 months--the length of the Peer Outreach Worker Training Course--separating the life experiences of peer staff from those of participant women." Interviewees stressed that the nurturing of team members required considerable time, ongoing support, a flexible approach to problem solving, and the willingness to take risks.

Research findings presented in this chapter demonstrate the overwhelming success of the HSMM peer outreach workers in connecting with participant women. It was apparent that the peer staff engaged in considerable "behind the scenes" work with participant women and that this activity occurred between the bi-weekly drop-in sessions. Program staff and community partners emphasized the significance of home visits, and regular phone contact in breaking the social isolation that many HSMM moms experienced on a daily basis. Peer outreach workers were involved in a diverse range of activities with participant women, including advocacy work necessary for practice and policy change at the provider and institutional levels. The peer staff's advocacy role was strengthened as they became more comfortable and competent in their positions.

Lessons learned described HSMM's empowering influence on the lives of the three peer outreach workers; their individual experiences of self-actualization that resulted in dreams and aspirations for the future; and the critical need for ongoing learning--both personally and professionally. Additionally, peer staff described the application of the learning in their lives, specifically as it related to their roles as parents of young children. Finally, HSMM peer outreach workers reinforced the need to keep things in perspective and spoke highly of the unconditional support and understanding that they provided each other.

CHAPTER 7

COMMUNITY ORGANIZATION IN HSMM

7.1. Introduction

This chapter describes the community organization process between 1995-1997 that resulted in the design and implementation of the HSMM Collaborative Outreach Model (Appendix C). The consolidation of the model between 1998-2000 is addressed in Chapter 8. The chapter is divided into two sections. Section 1 begins by defining community organization. The content in Section 1 focuses on the first three phases of the developmental process: Phase 1--"Preparing the Earth"; Phase 2--"Planning the Garden"; and Phase 3--"Planting the Seeds."

Section 2 summarizes the theoretical constructs underpinning the research findings discussed in Chapter 7. The chapter summary outlines the major research findings related to Phases 1 to 3 of the community organization process and links the findings to the theoretical constructs summarized in Section 2.

7.2. Section 1–Definition of Community Organization

According to Bracht (1999), community organization can be conceptualized as "a kind of glue" that keeps citizens involved in the process, nourishes community participation in programs, and develops the community capacity necessary to sustain successful intervention initiatives (p. 85). He defined community organization as

> a planned process to activate a community to use its own social structures and any available resources to accomplish community goals that are decided on by community representatives and that are generally consistent with local values. Purposive social change interventions are organized primarily by individuals, groups, or organizations from within the community to attain and then sustain community improvements and/or new opportunities. (p. 86)

Labonte (1994) described community organization as "the process of organizing people around problems or issues that are larger than group members' own immediate concerns" (p. 66). He distinguished between the two terms--community organization and community development--that are used interchangeably:

> Community organizing more accurately might be described as the process of building new, outward looking community groups, and as such is one aspect of community development, which as a health department practice has been defined as 'the process of supporting community groups in identifying their health issues, planning and acting upon their strategies for social action/change, and gaining increased self-reliance and decision-making power as a result of their activities.' (City of Toronto, 1993, p. 84)

The Empowerment Holosphere in HSMM (Figure 7.1) strategically situates community organization between the spheres of small group development and coalition-building and advocacy. Labonte considered that community organization was the key to reaching the upper "levels" of The Empowerment Holosphere involving coalition-building, advocacy, and political action. Chapter 7 describes how interdisciplinary team members and HSMM partners organized to take action on community-identified issues that were beyond the scope and/or mandate of any one agency or organization.

7.3. Community Organization in HSMM

7.3.1. Sphere of Community Organization

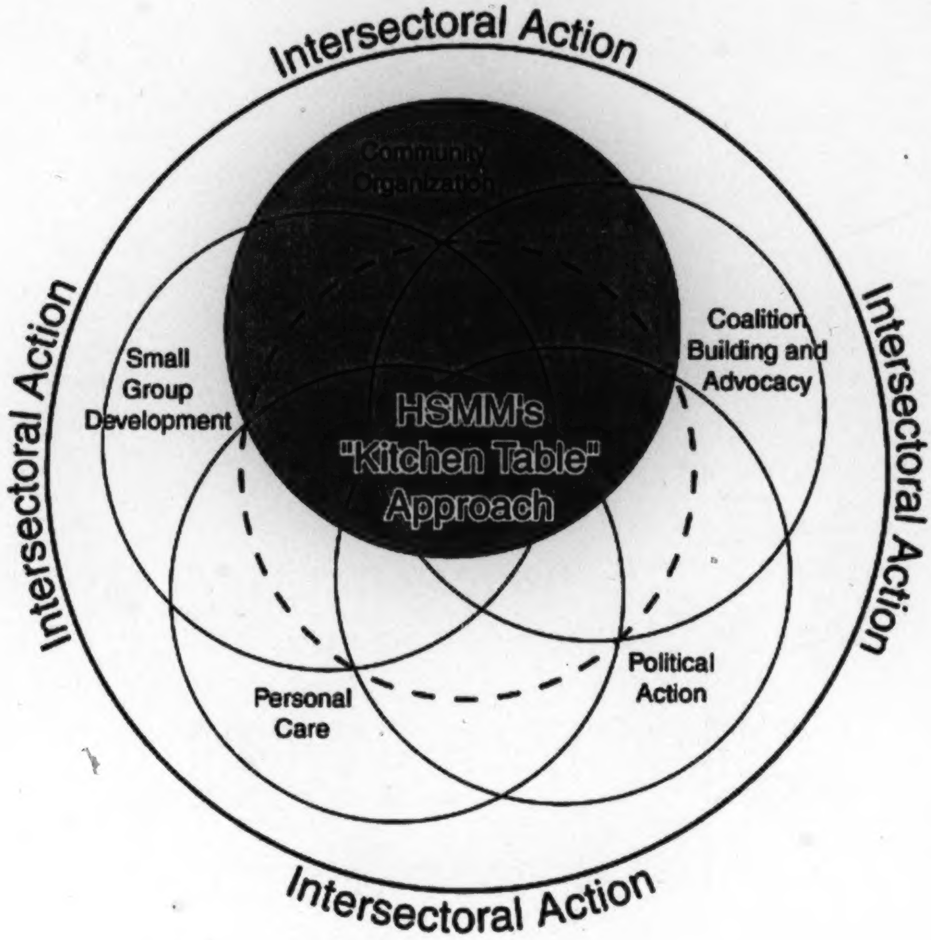

Intersectoral Action
Intersectoral Action
Intersectoral Action
Intersectoral Action
Community Organization
Small Group Development
Coalition Building and Advocacy
HSMM's "Kitchen Table" Approach
Personal Care
Political Action

Figure 7.1. The Empowerment Holosphere in HSMM (community organization).

7.3.2. Community Organization in HSMM–An Overview

HSMM outlined the community organization process that led to the development of the Collaborative Outreach Model in a flow-chart diagram (Appendix B: HSMM--Developmental Process). The process began in May 1995 with the hiring of the Community & Program Development Co-ordinator and ended in July 1997 when the program became fully operational. Between 1998 and 2000, HSMM was incorporated into the established structures and community-based networks. This two-year period of program consolidation is described in Chapter 8.

The developmental steps are not traced in a linear fashion. Rather, the story of the design and initiation of HSMM is told through the participants' recollections of their experiences. Their recollections are elaborated upon using field notes, historical documents, and other artifacts. Additionally, I have drawn on my memory and personal experience of the community development process between 1995 and 1997 that ultimately led to HSMM.

For organizational purposes, Section 1 is divided into three sections, each section dealing with a "phase" in the community organization process. I have used a gardening analogy to describe and understand these three highly interdependent phases: Phase 1--"Preparing the Earth"; Phase 2--"Planning the Garden"; and, Phase 3--"Planting the Seeds." The community organizing work described in each phase is dynamic. Additionally, the three phases commonly overlap and some of the tasks or key elements are repeated from one phase to the next. For example, program planning began early in the process (Phase 2) and the planning process was repeated in Phase 3 ("Planting the Seeds"). As well as being interdependent, each developmental phase relied on major strategies to simplify the complex work. I have elaborated upon these key strategies separately in relevant sections.

7.4. Phase 1–"Preparing the Earth"

Successful implementation of community-based health promotion and intervention programs depends largely on the experience and skill of the lead coordinator or organizer. Bracht (1999) described these individuals as "local field directors," and stated that community organizers must have the experience and skill to work with diverse groups and coalitions (p. 86). In addition to having a solid understanding of community change processes and proven management skills, they must be knowledgeable about local history and community values. The numerous interpersonal skills required of community organizers include facilitation, listening and conflict-resolution skills.

7.4.1. Securing a Sponsor

In the late fall of 1994, Health Canada (Health Promotion & Programs Branch, Manitoba/Saskatchewan Region) approached the Manitoba Association of Registered Dietitians (MARD) to request that the provincial nutrition-focused organization act as a sponsor and catalyst for the developmental phase of a CPNP-funded project in Winnipeg. MARD, a non-profit professional association with over 250 members, was supported by a part-time Executive Director. MARD's decision to sponsor the initiative was viewed as a short-term arrangement. The MARD Board of Directors assumed that the collaborative planning team would suggest another form of governance as the program became operational (HSMM, 1996, p. 11).

A funding proposal was developed and submitted to Health Canada. Early in 1995, the Minister of Health advised MARD that the funding application had been successful. In May, MARD took the initial step of recruiting a Community & Program Development Coordinator (Sarah) to begin to lay the groundwork for the initial stages of program development.

7.4.2. Recruiting a "Gardener"

Sarah recalled her early days in the position of Community & Program Development Coordinator and the Selection Committee's efforts to accurately define the brand-new position: *"I think we had the name changed a little bit at the beginning, because the first descriptor wasn't accurate. I suggested Community Development Coordinator might be the title that you were looking for."* Sarah stated that the original position, advertised in 1995, was described as a five-month term. She added that *I've been having fun ever since!"* She discussed her impression of the task at hand in May 1995:

> *Initially, I think the task was to sound out with the community whether there was a need for the program in Winnipeg and whether people might be willing to work together. I remember one question in the interview was: 'Can this job be accomplished in five months?' That's where I knew my watershed point was going to be. I think I said, 'Well, we can make a good start at it!' I tried not to rain on anyone's parade in terms of how long that process can take. I think we were well along at five months . . . enough so that Health Canada renewed some funds to let it keep on developing.*

A program report submitted to Health Canada in 1996 formally stated the primary goal and objectives of the initial five-month funding period: "to conduct the initial phase required to establish the Canada Prenatal Nutrition Program in Winnipeg through the development of a consortium model for the coordinated delivery of community-based prenatal services. The three specific objectives were as follows:

> (1) To bring together organizations that represent economically disadvantaged women in Winnipeg, and those agencies/organizations that currently provide community-based prenatal services; . . . (2) To establish a representative steering committee to develop a consortium model for coordinated prenatal nutrition service to economically disadvantaged women; . . . and (3) To evaluate the outcome of the developmental phase. (HSMM, 1996, Appendix 6: Phase 1--Project Development)

As a result of my involvement with the sponsoring agency (MARD), I participated in drafting the goal statement and objectives as they appeared in the 1996 report. The Health Canada program consultant recommended the use of the word "consortium." The word "consortium" did not re-appear in any other program documents reviewed during the data collection process. Nor was it used by the HSMM participants or Key Informants that were interviewed. This suggests that participants were not clear on its meaning, and chose to use the word "collaborative" or "partnership" instead.

Sarah commented on the fact that in hiring her, MARD (a professional association of dietitians) had resisted the temptation to hire "one of their own." She discussed the knowledge and skills that she brought to the Program & Community Development Coordinator position:

> *I wasn't a dietitian. That was probably useful, although originally I think it offended some dietitians. Once they realized that I had a commitment to nutrition, it paved the way. Maybe they saw that I had some skills that weren't necessarily skills that they would have attained through their professional training? Things like: experience building a program from nothing to something, and to its*

> *operational level; experience getting money and writing proposals; experience talking with a really wide variety of people within a service field, from the people who are the receivers of the service to the people who perceive themselves as the experts, and then all the people in between.*

Sarah elaborated on the broad range of experience she brought to the position, stressing her work with marginalized groups in Winnipeg's inner-city community:

> *I had been a keen volunteer in the Lamaze childbirth field, and was really interested in breastfeeding without being a 'born-again' sort of person. I'd worked with many different groups of people who felt marginalized, and so I was sensitive, I think, to those kinds of concerns and with how people liked to be heard and the way they need to feel, how to create comfort for that place to be heard.*

Sarah described her contribution to the community organization process, starting with Phase 1 of program design and moving into Phase 2--"Planning the Garden":

> *I guess my experience has been, that I'm the gardener . . . involved in planting some of the seeds, and doing the care and watering, and then watching some things grow. And watching the other little perennials and a lot of things come up around it. And I want you to know; I'm not a gardener in real life.*

Listening to Sarah compare her role to that of a "gardener," I started to think about using a gardening analogy to describe and understand the community organization process. Sarah further considered herself in the role of "gardener," and expanded on the analogy to include the concept of timing:

> *By using the gardening analogy, I don't want to sound like I felt I was in control of the process, because it didn't feel that way. I felt like I had some of the raw materials and vision for what perhaps could happen if we got the right weather. I think that the miraculous thing really was the great spirit that existed here in the community for this. We're often asked what were the ingredients, and when you go back to it, it's interesting to think about, because some of the ingredients were things like, in this field, people had talked with each other on the phone, but they didn't really have a history of face-to-face meetings, they really didn't have the history that gets in the way.*

Sarah offered the following thoughts on how the Winnipeg community initially responded to MARDs sponsorship of the initiative, given that this represented a new role for the Association. She pointed out that to the more experienced community-based agencies and organizations, MARD truly was seen as the "new kid on the block":

> *I think people realized early on that nobody could do it alone, and it was going to require pulling together, sort of shouldering this differently than it happened before. I think it really was advantageous that MARD spearheaded this, because they were an unknown quantity in some respects in the community, so that was fresh in itself, and a new presence on the playing field and an unknown quantity. I think that people were happy to leave it to the dietitians to take responsibility for it--especially because they* [MARD] *didn't seem like they were being too pushy.*

Alison, an original member of the HSMM Steering Committee with considerable experience as a public health nursing manager, concurred that Health Canada's decision to ask MARD to sponsor the initiative made good political sense. Alison contemplated whether Public Health Nursing could have assumed the role of sponsor, and concluded that, of the two, MARD was the better choice:

> *Public Health being a partner* [as opposed to taking on the role of the sponsor] *was probably the best way to go, because I think that the sponsor* [MARD] *could do a lot of other things that we may have been constrained due to being connected with government at the time. Definitely, we couldn't always go and lobby or advocate as much as the sponsor could. So, I think that way it was really good.*

According to Rachlis (1998), the choice of the program "lead" is a critical consideration in building intersectoral partnerships. He cautioned that health professionals must not force their leadership. Rachlis stated that "other [non-health] sectors have balked at particular intersectoral actions because they have seen the intervention as health imperialism" (p. 20). The fact that Sarah's background was in the community services field, and not in health, may have facilitated the community-organizing process.

7.4.3. The Significance of Timing

Sarah recalled the atmosphere of excitement and the palpable feeling of anticipation among stakeholders as she laid the foundation for the initial community consultation, held in June 1995. According to Sarah, Health Canada's desire to avoid competition among agencies for limited funds, and wish to encourage a co-operative, city-wide strategy, was critically important in encouraging stakeholders to work collaboratively:

> *There was a lot of magic stuff, though. It did seem that people were ready, they were willing, the time was right, and there was money. I think the fact that there was money committed from Health Canada made people feel it wasn't just a shot in the dark, where you never know where it was going to go, and a lot of effort for nothing. The people felt that there really would be money coming into the province. If we didn't do it, no one else was going to do it, because it wasn't going to be a competitive process. So, those were useful things.*

Nan, an ex-staff member of HSMM, also questioned the significance of timing, and she commented in this way on the Winnipeg community's readiness for change:

> *Do you think it was partly the timing? There was the report on poverty in children, and Winnipeg had the highest child poverty rate in Canada. I think that the community could do nothing but respond to that. How could you, in any kind of political climate, live comfortably with that kind of report?*

Nan referred to the persistent and deepening poverty in Manitoba, as reported by the Social Planning Council of Winnipeg (1989). Data presented in The Manitoba 1999 Child Poverty Report Card indicate that Manitoba had the highest child poverty rate in Canada in 1989. Between 1989 and 1997, Manitoba remained in the top three for the entire period. The depth of child poverty is the difference between the amount required to reach the LICO (Statistics Canada Low Income Cut-Off) and the average poor family's income. Almost one in four children in Manitoba presently lives in poverty. The average child poverty rate for Manitoba between 1989-1997 was 24.4%. The 1989 and 1997 figures show only a 0.6% improvement. While child poverty in Manitoba is highest in urban centres, it also shows up throughout the province in rural and northern settlements of various sizes.

Nan contemplated why the community enthusiastically embraced the opportunity to work together to break the cycle of disadvantage. She referred to the negative impact of health care reform and suggested that the influx of federal funding offered service providers an opportunity to "*rebuild*":

> *I would say that they recognized that they could do more to reach a highly vulnerable group, and that it's in the best interest of the community to do that. There is a whole recognition of birthweight as a critical determinant of future health and the whole healthy child development piece. So I think maybe it was timing. Things had been stripped away so badly--here was an opportunity to rebuild. It was an opportunity to team up with other service providers and make your resources go further.*

7.4.4. Health Canada's Contribution

Sarah was asked whether she had found the information from the National Office of CPNP (program guidelines, goals and objectives etc.) to be helpful during the initial phase of community organization. She replied in this way:

> *I think that they were exceptionally useful. Knowing that Health Canada had done a few years of work, of real country-wide consultation, and thorough both research and analysis of what women were telling them, what their literature was telling them, and looking at this with real integrity, and so they put out some documents that mattered, I think, and some guiding principles that mattered.*

However, Sarah's experience as a community organizer came to light when she cautioned that, at a local level, people needed an opportunity to personalize the national guidelines to give them a local feel and flavor, that is, *"to make them their own."* Her comments reflect a "power with" versus a "power over" approach (Labonte, 1994) to community-based programming:

> *What we were careful to do, as a group was to say, 'Let's look at this with our own lens first and come up with our principles and values and then look at Health Canada's and see if they match.' There was a direct match; it was perfect! It didn't feel as if we had to conform to something that wasn't totally agreeable . . . there was high congruence with the funder. I think it was beautiful what Health Canada did, really, with this particular program. It was more carefully thought out than most programs than I've seen over my gazillion years.*

Denise, a manager working in the National CPNP Office in Ottawa, reflected on the national launch of the program and acknowledged that, in her opinion, the Federal Government had given up some control in order to ensure that regional programming addressed the needs of communities:

> *It's a miracle to me that the federal government was able to announce something like this, a national program, that really is totally dependent on the individuals who are involved in it, at all levels, for its success. I'm not taking about the participants . . . . I'm talking about the way it was first spun out by the Joint* [Federal/Provincial] *Management Committees, the way the very first early organizations were brought on as partners and coalitions, the way it then went to the community, how the staff have been hired and projects named; . . . all of those pieces between when it was announced and the way it looks now, were really not laid out; . . . they were left to the community, and to the people. And the success we have had is really due to that and not to, I would say, the eight items that we said need to be involved in a comprehensive prenatal program.*

Denise suggested that the National CPNP Office's decision to relinquish some control of the program was not easy. Past attempts, in other program areas, had not been successful because Health Canada policy advisors and programmers felt that a strong national grip was necessary to maintain the integrity of the program at the community level:

> *The phrase the 'integrity of the program' has been with Health Canada for years. I remember an earlier program,* Nobody's *Perfect. . . . It came from a community (the four Atlantic provinces), and everybody across Canada really wanted it. We were a partner, but the biggest hurdle, and it took us two years to decide if we should do this . . . . Should we give it to the community? How would we maintain the integrity of he program? People might just take it, and they might use the books without having the whole two-week course to go with the books. And what we didn't understand then, but we know now, is that people take it if they want it and they need it, and they'll use it, providing they want it and need it. And, there'll always be people who don't even need it, but they want to have the program on their shelf, and that's fine. But I think that CPNP has really demonstrated the power of the people to come up with something.*

Denise attributed the success of CPNP to the "bottom-up, community-paced" approach to program design and implementation at the local level, and the fact that the control of projects was ultimately left in the hands of the communities. This approach closely matches the "strengths-based," "community-centred" models to community empowerment depicted by Minkler and Wallerstein (1997) in Figure 2.1.

7.5. Phase 2--"Planning the Garden"

The HSMM Developmental Process (Appendix B) indicated that Phase 2--"Planning the Garden"--began in June 1995 with the first community consultation, and continued over the summer and fall months. During this time period, Working Groups met on an ongoing basis to discuss common goals and values and they attempted to reach consensus on current gaps in service delivery. By the completion of Phase 2 in October 1995, the goals and objectives for a new community-based prenatal nutrition program had been drafted. Additionally, a proposed program model (Appendix C: HSMM Collaborative Outreach Model) had been affirmed through the community consultation process. According to Bracht (1999),

> The community organization process often begins with two interrelated sets of activities: (1) an accurate analysis and understanding of a community's needs, resources, social structures, and values, and (2) early citizen leader and organizational involvement to build collaborative partnerships and facilitate community participation. (p. 92)

Bracht maintained that assessing community capacity to support a project, identifying possible "road blocks" to implementation, and evaluating community readiness for involvement are all key pieces of the community analysis.

As depicted in the HSMM--Developmental Process (Appendix B), 50 representatives from 30 diverse groups participated in the first community consultation held in June 1995. An evaluation report stated that the outcomes of the consultation were "consensus about needs, enthusiasm about working together and the formation of a Working Group" (Healthy Start for Mom & Me, 1996, Appendix I). The Working Group of 19 members met seven times between July and October 1995. The stated outcome of their work together was "consensus on gaps, philosophy, features to borrow from other programs, goals, food and peer support strategy, and a proposed multi-site cooperative model for the program" (Healthy Start for Mom & Me, 1996, Appendix I).

The second community consultation took place in October 1995 and involved 40 representatives from a wide range of groups and organizations. The evaluation of the second consultation stated the outcomes as "affirmation for the proposed program model, goals and objectives" (Healthy Start for Mom & Me, 1996, Appendix I). The Working Group was re-configured at this time into the HSMM Steering Committee involving 20 people, including representatives of the target population.

Phase 2 of the community organization process ("Planning the Garden") has been described through the experiences of participants over a loosely configured five-month period. Program reports, field notes, and other historical data have been used to complement the quotes and increase understanding of how the planning process evolved. As stated earlier in this chapter, the three phases of community organization are highly interdependent, and the work is dynamic in nature. Therefore, it was difficult for interviewees to "slot" their experiences into specific time periods. Participants' recollections of their experiences tended to be general, and occasionally their memories of specific decisions or strategies had faded. They were inclined to recall overall feelings or events of the program planning process, but their stories often lacked specificity of time, person, and place. This was not surprising given that the Phases 2 and 3 of the community organization process spanned a two-year period.

7.5.1. Starting With the Voices of Participant Women

Bracht's (1999) definition of the community organization process emphasizes the importance of starting by "identifying early citizen leader and organizational involvement to build collaborative partnerships and facilitate broad community participation" (p. 92). The Winnipeg initiative realized the importance of actively involving another critically important group--the intended recipients of the services, respectively referred to as "the moms." Repeatedly, participants referred to the importance of involving the target population in the process, and explained why the women's participation was so important. In the words of Sarah, *"The key thing here was starting with the voices of women who had experienced poverty and pregnancy. They were front and centre. It helped focus and refresh the professionals, I think."*

Sarah recalled meeting with a group of women/teens to talk about the planning that was underway from the first community consultation and to explain why their participation was so important. The majority of the women were not formally "attached" to a community agency or organization at the time. Their participation at the initial community meeting was apparently the direct result of Sarah's ability to secure their trust and to sensitively seek their involvement. Repeatedly, interviewees were adamant that the women's voices contributed to the community organization process in a unique and a meaningful way.

Sarah contemplated how the women's decision to participate came about, the nature of their involvement at the first meeting, and their continuing participation in the initiative:

> *They self-selected--there was a group of moms we heard from as almost panels (too formal sounding a word), that first time we met. We asked all of them whether they might like to stay involved and come to regular meetings. Out of that, there were about five or eight--I can't remember, quite frankly--how many, and they hung in through that.*
> Interviewer: *And these were the moms that actually named the program?*
> Sarah: *Yes, they named the program. And I think it was fun for them. I think we all learned a lot.*

Sarah did not mention the critical first steps that she took to facilitate the women's participation on an ongoing basis. In this "pre-negotiation" stage of coalition building, the HSMM Manager worked with participant women to establishing close and trusting relationships. This was consistent with the "midwifery role" of community developers described by Gray (1989), and cited in Labonte (1993). Sarah encouraged the women's involvement by assisting with transportation to planning meetings and babysitting, as necessary. Additionally, Sarah offered the women/teens honoraria, when appropriate, to recognize their valued contribution to the process. Sarah's efforts to keeping the meetings friendly, low- key and informal also facilitated the women's participation, as did tasty and nourishing snacks or meals if the meetings went over the lunch hour. These "hooks" are considered critical elements of grassroots organizing and are described further in Chapter 4.

One of the women (Debbie) who participated on the "panel" at the initial community meeting in June 1995 agreed to share her written remarks with the Program & Community Development Coordinator. The "talk," entitled *"Memories of Being a Single, Teenage, Low-income, Expectant Mother"* was included in a program document submitted to Health Canada, in 1996. After actively participating in the initial consultation, Debbie volunteered to become a member of the Working Group responsible for developing the Winnipeg-based project strategy. Excerpts of parts of Debbie's "talk" have been included because her messages were very powerful and they assisted in keeping participants focused on the identified needs of the target population:

> I don't remember my pregnancy as being a joyous occasion or having that pregnancy glow. I remember it as a time of guilt, depression, and frustration. My daughter was considered a low birthweight baby. She left the hospital at five pounds. I was expected to have a 7-8 pound baby. During the last week of my pregnancy, I weighed 158 pounds; about 8-10 pounds more than I weigh now (and I am slim).
>
> First of all, I would like to tell you a bit about how it was being on low income and trying to have proper prenatal nutrition. I was on city welfare during my pregnancy and was receiving $220 a month for food, clothing, phone, and bus fare--everything except rent. I never did spend my money on clothes; it went into my grocery money. I could never make my money go for the full month and had to resort to borrowing and pawning some of my possessions in order to get money.

> There were days at a time when I never had milk or fruit or vegetables. Some meals were noodles and water and that's all. I was not spending my money needlessly. It was that I could not make it last for the whole month. You can't imagine how it feels to go to bed at night knowing you have not had enough food to keep yourself healthy, let alone the child you were carrying. It was impossible to eat properly with the money I was receiving. It was a very depressing time in my life.
>
> I had received prenatal supplements from my doctor and some days that was the only nutritional thing going into my body. I felt tired and drained most of the time. This only added to the problems I was facing. I made the choice to have this baby but I had no idea it would be so difficult just trying to be healthy during my pregnancy. (Healthy Start for Mom & Me, 1996, Appendix H)

Debbie concluded her "talk" by focusing on the kinds of things that would have been helpful during her pregnancy: "All I needed was some extra food, a couple of litres of milk and information on prenatal nutrition. It's not much to ask for when you have suffered the way I did after my daughter was born."

Debbie went on to explain that in the year following her daughter's birth, she experienced serious dental problems, including "three oral surgeries, one emergency root canal and approximately 20 dental appointments." She attributed the loss of over half of her teeth to both heredity and poor prenatal health:

> All my teeth will eventually be pulled because I can't reverse the damage that has been done and neither can my dentist. At the age of twenty-one, I have upper and lower partials [plates]. It is not something that I am happy about, especially if it could have been prevented. (Healthy Start for Mom & Me, 1996, Appendix H)

Another woman (Paula) who participated on the "panel" at the initial community consultation, and is now employed by HSMM as a peer outreach worker was interviewed by the researcher. She spoke of the negative stereotypes that unfairly portray mothers, like Debbie, as irresponsible parents and less-than-desirable members of society:

> *One thing that is definitely out there is the belief that these women keep having babies. I'm being very sarcastic right now, but you hear from different places that these women keep having babies and they're not having healthy babies and all this stuff, and it's like taking away from the women, that she doesn't care about being a mother, that she doesn't care about having a healthy baby.*

A senior politician in Manitoba's New Democratic Party government (Mr. Fred Holt), who represented an inner-city constituency in Winnipeg, spoke of the negative stereotyping and the discrimination that people on social assistance encounter. His comments reflected the highly political context of contemporary health and social issues. Mr. Holt spoke frankly about the difficulty that welfare recipients have encountered in Manitoba under the previous political regime:

> *There's no question that they're up against what for the last 10 years has been a neoliberal mindset that somehow is quite prepared to punish unborn children in order to work out its anger against welfare recipients.And I think that's a sad commentary on neoliberalism--that it's quite prepared to cut off its nose to spite its face.*

This series of quotations from Debbie, Paula, and Mr. Holt began to describe the discrimination, personal hardships, and social isolation experienced by the HSMM target group on an ongoing basis. I realized that this section barely "scratched the surface" of the many layers of participants' life experiences. These issues are discussed in Chapter 4 through the stories of program staff, community partners, and HSMM participants.

Nan recalled the impact of the women's stories on a very personal level. Nan's comments emphasized the importance of actively involving the moms in all phases of the community organization process. The following quote suggested that Nan was disturbed by what she saw happening in the world around her, and that she was profoundly affected by the stories that the women shared so eloquently:

> *I'm a middle-class woman with two kids who do well in school. I felt that in the years leading up to it* [the launch of CPNP] *that the world was becoming an uglier place. Even if I could manage to survive and give my kids a good education, be well fed and have clothes, I didn't like the world that they were going to experience. I was worried about what was happening to all of those other kids and what kind of things were being bred in those kids: the resentment, being bombarded with images of 'you can have anything,' but actually not having resources to get it. I was worried that my children would grow up in a much more violent world than I did, and that they would not be able to feel as safe, or trust or whatever. And I worried a lot, and I saw this offer as a glimmer of hope that somebody is starting to put the resources together in a way that will redistribute income, that will give all children an opportunity to reach their full potential, and it gave me hope.*

Another interviewee (Ralph), employed as a Facility Supervisor at one of the HSMM sites, also spoke of the mother's stories affecting him at a deep, very personal level. In contrast to Nan, Ralph does not have children. He stated that the participants' stories of personal hardship and survival caused him to think of his mother--a young Italian immigrant who arrived in Winnipeg alone, unable to read or write, without a source of income, and faced with the daunting task of raising a young family, on her own:

> *I come from a European background where my Mom came to Canada very young, without speaking English, and tried to raise us. She was really illiterate in all languages, even Italian. I think about that . . . . We were not well nourished. She tried her best to feed us properly, . . . vegetables, milk, and all the protein necessary for a healthy lifestyle. But, she just couldn't do it. We speak about it to this day. She just didn't know. I see this program where they talk about the diets of their children, about themselves, about help with their child, what kind of diapers, and stuff. I think that that would have been unbelievable for my mother to have had the opportunity to be part of this program. I just think it's such a helpful program to anyone who's raising children for the first time.*

Victoria, a dietitian, who represented MARD on the initial HSMM Steering Committee, also had vivid recollections of how the women's stories affected her at a very personal level:

> *It's a very humbling experience, I think. It puts into perspective your own role as a parent, a professiona . . . as somebody who lives in a particular fashion. These people live in a different place, and the system is fractured, and even professionals have trouble getting through it, so how do you even hope that a fifteen-year-old can make it? I think of myself, I look back at my experience parenting babies and think, Good Lord! I couldn't have done it without the social supports that I had in place.*

In the following quotation, Sarah stated that *"starting with the voices of moms"* was central to the community organization process. Her comments echoed Labonte's (1994) advice to practitioners: " If we fail to 'start where people are', if we seek to impose our health concerns over theirs, we risk . . . being irrelevant to the lives and conditions of many persons" (p. 31). This section closes with another quotation from Sarah in which she reminded us that the participant women do not necessarily have all of the answers to the complex issues that they are struggling with and that, in fact, no one group has all of the answers:

> *I know that sometimes you can get bogged down expecting all the answers to come from one particular sector, like receivers of service, and it usually doesn't happen like that. That's why I feel really thrilled to have been involved with this.*
>
> *I got to work with people differently, so that participant women felt that they were being heard by nurses and dietitians and other agencies, and that no*

> *one voice dominated. We worked together, to knit together, all those voices rather than any one group being the expert. Well the women were so clear about their own experiences, and what they felt might have worked better, they weren't making any claims to know how to do it, but were willing to work along with others who seemed to have those skills.*

Sarah's comments on the community organization process in HSMM reflected one of the "terms of authentic partnerships" described by Labonte (1993):

> All partners respect each other's organizational autonomy by finding that visionary goal that is larger that any one of their independent goals. This requires extensive 'midwifery' work, to set the shared agenda. Achieving this shared agenda is another facet of community development work. (p. 83)

7.5.2. Collecting Community Data

A funding proposal submitted to Health Canada in February 1996 re-capped the highlights of Phase 2 of the community organization process:

> Enthusiasm was high in the community to participate in such a venture, probably fuelled by discovery of commonly held concerns and philosophy for tackling the complex issues, as well as by clearly expressed desire to 'do things differently' and avoid the usual turf concerns amongst agencies. As well, many appreciated the explicit focus in meeting processes on the real experience of low income mothers made concrete and invisible by their involvement . . . . We have made a point of learning about other prenatal outreach programs and have distilled many of our program ingredients from the best features of other programs. (p. 3)

This quotation referred to the collection and analysis of a variety of data including information on local social and health issues, community needs, current levels of activity, barriers to taking action, potential resources, and the community's readiness for change.

Program documents prepared in early 1996 summarized the data captured and described the local context for the development of a CPNP program as follows:

- High rates of teen pregnancy and child poverty in Manitoba, as compared to the rest of Canada;
- In Manitoba, 60% of low birthweight (LBW) babies are born in Winnipeg;
- Winnipeg (and Manitoba) is underserved in this area, as compared to other provinces;
- [In the Winnipeg area] prenatal services are fragmented with little nutritional input;
- Recent Manitoba reports--Nutrition Services Review (1994) and The Health of Manitoba's Children (1995) both refer to needed prenatal nutrition for

> low-income women and *"that prenatal health be identified as a priority health policy objective"* (Healthy Start for Mom & Me, 1996, p.4).

A program report submitted to Health Canada in 1996 featured a detailed description of local barriers to prenatal services, attributed to living in poverty. This information was largely gleaned through the community consultation process. The most salient points are summarized below because they represented the barriers that the new program model attempted to address:

> - Pregnant women who live with poverty and other issues face enormous vulnerabilities and stresses that challenge traditional medical practice. . . . It is obvious that economically disadvantaged pregnant women are least likely to be able to eat the recommended amounts and variety of wholesome foods to maintain fetal and personal health.
> - Many pregnant women and girls do not seek, but avoid and are afraid of medical care. . . . Social isolation and lack of any emotional support distance these women further …and result in their being "hard to reach" and needing extraordinary time and reassurance in any social context.
> - With little education or poor reading skills, these women cannot be assumed to have clear concepts of nutrition, health, and fetal development. Mainstream printed materials simply do not meet their needs. Other cultural, language and attitudes of these women do not match up with the assumptions of the traditional medical system.
> - When coping mechanisms involve alcohol, drugs, and smoking, women are also concerned about being judged negatively by the service-providing professionals. As a result, they tend to preserve their social isolation--it probably feels safer. (Healthy Start for Mom & Me, 1996, Appendix F).

The report concluded with the following statement that highlighted priorities for service delivery: "What is important to the Winnipeg project is this: with sensitive contact, support, and food supplementation, it is observed that healthier babies can be born of low-income, high-risk women" (Healthy Start for Mom & Me, 1996, Appendix F).

The funding proposal submitted to Health Canada also included a copy of an editorial entitled "The Diet Divide" printed in the Globe & Mail on January 6, 1996. The article appeared to have meaning for the HSMM Steering Committee because it highlighted the growing gap in access to credible, culturally appropriate sources of nutrition information. According to the author of the editorial, "There is no reason why the nutritional knowledge-power that benefits middle-and-upper-income Canadians cannot be made available to all, in forms that are readily comprehensible even to those who lack literacy, resources and time."

It was interesting to re-read the 1996 article and to reflect on the author's assumption that nutritional knowledge led to increased personal power resulting in healthier food choices. Today, it appears very obvious that the other broad determinants of health, especially income, and its relationship to nutritional status, were not been fully appreciated by the Globe & Mail editor. Given this limitation, I questioned whether if the HSMM staff would be as impressed with the article today, as they were in 1996.

7.5.3. Achieving a Common Vision

In Kingsbury's (1999) view, collaboration between community agencies and organizations is more successful when a clear purpose is defined and agreed upon by the partners (p. 225). Sarah expanded on her recollections of the community consultation process, and her role in particular in assisting participants achieve a common vision:

> *What was fun that first meeting was realizing that people were truly excited to be in the same room with each other, to put a face to a name, and genuinely seemed to want to work differently this time without turf issues and territoriality. And they just didn't want to get bogged down in politics. And so that was a challenge to try to honor that, but it also gave great permission to trying to do things a little bit differently, to clear the deck so that could happen.*

Judy, a community dietitian, and a member of the HSMM team, recalled her experience in the initial planning meeting and Sarah's contribution as group facilitator: The following quotation sheds light on the dietitians' role in the community organization process:

> *Sarah was great in helping us develop a vision of how do we go about trying to put it together. The first meeting, invitations were sent out to a number of different agencies to come together and try and decide: Can we develop a vision of how to get going . . . how do we get started on something that would be different, something that had never been done before here in Manitoba. People were identifying all different kinds of needs with women and with their own agencies and organizations as they saw it. Something different to address those needs and the gaps as they saw it. It was wonderful to talk with those people. And I recall the feeling of excitement that was there by the end of the day.*

At this point in the interview, Judy contemplated her participation as a member of the initial Working Group. She discussed how she often felt at the conclusion of a planning meeting:

> *The feeling was the same. We all saw a need and wanted something to come out of the meetings, something that could happen in the future. And at times, it was really confusing. It was so hard to envision what would happen. One of the things that was really valuable at the very beginning was young women coming and talking about their experiences. There was no doubt in any of our minds what we needed, we felt really compelled to do something to address the needs that those women and girls identified. So there were a lot of people involved, and we were breaking into small groups all the time because of the number people there, and it was really valuable work to try and envision everything.*

Paula, a single mother who represented the target population on the Working Group committee, recalled her experience of the planning process and the visioning that resulted in the development of the HSMM Collaborative Outreach Model (Appendix C):

> *I think that an amazing group of people got together, just looked at it, and saw it. And I don't know what it's about, because I couldn't imagine doing it any other way. Everyone together, community members too, were saying: 'We've got to do this differently. What is going to work? How are women going to trust coming to a program like this? How are we going to break those barriers?' So, it was everyone's experience in the community that just came to that--everyone together.*

7.5.4. Encouraging Shared Values

Sarah's recollections of Phase 2--"Planning the Garden," were very similar to those expressed by Paula. Additionally, Sarah remembered a challenging time of "suspended animation" where people had to trust in the process, and really believe that out of the confusion something unique would emerge:

> *I end up coming back to our origins where we all kind of agreed, 'Let's start from the experience of women, but then let's make sure we're philosophically in agreement.' I remember saying to the group at the time, 'I know you're not going to believe me on this, but I just need you to trust me through a period here. It's going to matter later if we have the same values around this or not, so let's make sure we've at least got some key things in place.' And it has been useful, because you can go back to it and you say, 'When we started out, we all agreed this or that or the other thing.'*

The philosophy or values that Sarah referred to above were drafted during Phase 2 of the community organization process and were included in a funding proposal submitted to Health Canada in 1996. There were 11 value statements in total; I have excerpted the ones that appeared to have had the most direct impact on the development of HSMM's Collaborative Outreach Model (Appendix C):

- We believe that to appeal to women in economic stress, informal friendly activities that offer concrete practical help are necessary.
- We believe that program participants can and should determine their own needs.
- We believe that responsive communities and neighbourhoods are an important aspect of social health and that "social service" initiatives should foster community involvement.
- We believe that community service organizations, "institutions," and informal associations can and should work cooperatively on their common interests: people. (HSMM, 1996, p. 4)

During Sarah's interview, she discussed the importance of "writing down" and widely disseminating HSMM's common philosophy/values statement to partner agencies and organizations:

> *I think that the goals had an authenticity in spite of the fact that it was driven by the availability of money. I like to think that we came together really clearly on the goals of reaching isolated women and dealing with the nutrition issues and health of the family, and that one of our goals was to work at enhancing the existing services and working more collaboratively. And by writing that down, I think that's been useful because you do hold yourself to that, but that isn't just part of window dressing; it is a key piece of trying to make this happen in Winnipeg in an effective way.*

Sarah's comments are consistent with one of the "terms of authentic partnerships," described by Labonte (1993): "Clear objectives and expectations of the partners are developed. The partners create a commitment among themselves to jointly 'manage the problem domain' (p. 83)."

7.6. Phase 3–"Planting the Seeds"

Following the community analysis and the identification of local priorities, the design and initiation of a community intervention began to take shape. According to Bracht (1999), this phase of community organization "begins with the formalization of a structure to elicit and/or coordinate broad citizen support and involvement" (p. 94). Building on the mobilization of selected individuals that occurred in phase two, this phase of community organization "extended the reach" of the initiative in the community, and solidified its partnership base. Bracht (1999) described actions that can occur as decisions are being made about the design and initiation of the intervention:

> identifying individuals who may wish to participate on a community board, coalition, or similar structure; contacting individuals to serve on the board or solicit interest; developing working relationships between the project and various collaborating public and private groups; and legitimating the board's activities within the community. (p. 94)

The flowchart in Appendix B (HSMM--Developmental Process) suggests that Phase 3 began following the second community consultation in October 1995 and continued until January 1997 when the program became fully operational. This was an extremely busy time in the design and initiation of HSMM, and the flow chart highlighted only the major activities. Participants' recollections of this phase were vague, with two notable exceptions. First, community partners spoke at length to the motivating factors behind their decision to come "on board." In sharing their recollections, they provided detailed explanations as to how the partnership between their organization and HSMM evolved. Second, several interviewees recalled the process of site selection, in particular how consensus decision-making was used so effectively to make the "hard" decisions on the locations of the eight neighbourhood-based HSMM sites.

Additionally, Phase 3--" Planting the Seeds" employed specific strategies to make an overwhelming task manageable. The following description relies heavily on archival records, program documentation, and artifacts. The initial strategy involved establishing a core planning group and an organizational structure.

7.6.1. Choosing an Organizational Structure

In October 1995, the 19 members of the HSMM Steering Committee "rolled up their sleeves" and made a commitment to participating in the design and initiation of the project. Between October 1995 and April 1996, seven plenary meetings and approximately 10 subcommittee meetings took place. Steering Committee members also participated in a variety of activities to increase community recognition of the initiative (Appendix B: HSMM--Developmental Process).

The three subcommittees included (a) Program and Administration, (b) Resource Materials, and (c) Healthy Baby Month Activity. An evaluation report submitted to Health Canada in 1996 defined the collective outcomes of the subcommittee work as resource development (i.e., criteria for the selection of resources, translation requirements etc.); development of training plans and position descriptions for contract staff; food coupon planning; and the involvement of other stakeholders in issues related to the distribution of prenatal vitamins.

The HSMM Steering Committee approached MARD and requested that the association remain a sponsor of the program for the fiscal year April 1996-March 1997, with a caveat that the program's governance structure would be re-assessed at that time. Additionally, MARD was asked to formally recognize the HSMM Steering Committee as a MARD Board committee having both advisory and decision-making roles. An HSMM program report completed in 1996 stated that *"MARD strongly believes in the program, its direction and its collaborative make-up and agreed to continue as sponsor"* (Healthy Start for Mom & Me, 1996, p. 11).

7.6.2. Defining Program Goals and Objectives

By the conclusion of the second community consultation in October 1996, the proposed program model had been affirmed. Program documents submitted to Health Canada defined HSMM, for the first time, as

> A flexible and practical citywide resource for low income, high risk pregnant women offered at several neighbourhood centres. This preventive initiative is intended to encourage healthy pregnancy and healthier babies through provision of social support, basic food and vitamins, promotion and support of breastfeeding, and related informal health education. This co-operative plan is based on a philosophy of community development, enhancement of current local programs, and the value of sensitive outreach and self-help opportunities for women who experience multiple stresses in their lives. (Healthy Start for Mom & Me, 1996, p. 2)

At this point in the community organization process, the program was designed to take place at multiple sites, in the form of bi-weekly "drop-ins." The model was premised on the use of existing local resources in conjunction with new and needed prenatal nutrition services. Peer outreach worker and a dietitian-coordinator comprised the "core staff" that worked as a team with other agency workers in delivering the program. Additionally, the core staff would follow-up with participant women in their homes.

The program goals and objectives that had been drafted during Phase 2 were formally affirmed at this time, through the community consultation process. They appeared in a program document released in 1996, along with proposed activities to accomplish the objectives. The four goal statements and accompanying objectives were not ranked in order of priority:

Goal 1: To reach isolated, traditionally hard-to-reach, low income, high risk* pregnant women (*high risk refers to other factors such as single, teenager, smoker, use of drugs or alcohol etc.)
1.1 To provide personalized support to pregnant women and new mothers,
1.2 To ensure that there is at least one source of emotional/social support for the pregnant participant, . . . and
1.3 To develop strong program awareness and referrals with all possible contacts of the pregnant woman (doctors of high risk women who do not return for prenatal check-ups, social allowance staff, food bank sites, outreach services of other programs, etc.)

Goal 2: To enable low income, high-risk women and new mothers to make healthy food choices.
2.1 To provide basic supplemental food and vitamins,
2.2 To improve the food intake of participants,
2.3 To increase knowledge of nutrition and health, specific to individual needs, and
2.4 To promote initiation and duration of breastfeeding.

Goal 3: To enhance the ability of low income, high risk pregnant women and new mothers to improve their health and that of their families.
3.1 To gain awareness of community and health resources, and use them,
3.2 To gain increased awareness of impacts of foods eaten (quantity and quality), smoking, eating disorders, and alcohol and drug intake on fetal development and health,
3.3 To decrease or stop cigarette smoking,
3.4 To reduce or stop use of alcohol and drugs,
3.5 To gain awareness of breastfeeding benefits and show comfort with nursing – demonstrated by choosing to breastfeed, or by giving it consideration,
3.6 To increase knowledge about infant nutrition, and
3.7 To have healthy full-term babies weighing more than 5.5 pounds.

> **Goal 4:** To strengthen, link, and enhance existing Winnipeg prenatal services that share concern for low income pregnant women and their babies, and, encourage natural community-based responses and resources.
>
> 4.1 To utilize neighbourhood venues for 'drop-in" activities for participating women,
>
> 4.2 To offer centralized, practical resources (food and vitamins, nutritional expertise, peer support, outreach, health and nutrition promotion resources) to neighbourhoods and local services, . . .
>
> 4.3 To coordinate, collaborate, and share resources in a variety of ways to decrease fragmentation and increase the base of community assets available to address the issues. (Healthy Start for Mom & Me, 1996, pp. 5-8)

7.6.3. Tensions Related to HSMM's Emphasis on Nutrition

In the process of interviewing program participants and Key Informants, the interviewees did not specifically refer to the four original program goals stated above. That, in itself, is not surprising given that the goal statements were developed close to four years ago. Consequently, the question: "How would you describe the HSMM program to a family member or friend?" was found to be very helpful in understanding participants' experience of the program. Subtle differences in perceptions were obvious from their responses. The differences appeared to be related to the emphasis that participants placed on "nutrition," in their description of the program. Some participants chose to describe HSMM as a "prenatal nutrition program." Others, described HSMM as "comprehensive health promotion program," and did not specifically use the word "nutrition" in their answers. The following series of quotations illustrates these differences in the participants' perceptions:

> Kathleen: *I'd say that HSMM is a prenatal nutrition program. I'd tell them where the funding came from, and that it was established to be able to connect and address the needs of pregnant women who are often in disadvantaged circumstances, or poor, and don't access traditional services available to the rest of the community. I'd explain that it's situated in the community where women live, that it was developed to be very warm, welcoming, and friendly and not threatening; and that everyone would be welcome and come as you are. It was done informally, it's very supportive. The nutrition piece is a very important part of it; the women are provided with information on different issues related to nutrition, not in a lecture-format or pamphlets or books, but in ways that are usable and accessible to them. There are hands-on opportunities to do cooking; that there's information about pregnancy, right from the beginning and going into the postpartum period. That it's not only delivered by caregiver to client, but it's*

> *also client-to-client . . . there's a lot of effort, I think, in terms of those relationships.*

> Alison: *I describe it as a community-driven, non-threatening, friendly service that provides support to prenatal moms and their families. See, I don't even use the words 'health promotion' or 'nutrition' when I describe HSMM, because I think those may be the focuses, but there's so many underlying things that happen when we look at the broad determinants of health. To single out one . . . I think there's many, many facets.*

> Susan: *It* [HSMM] *grew out of a concern for nutrition for moms and infants, and the nutrition is a major part of it, even though we don't talk about nutrition per se, or use the word very much. Any nutrition information comes in casually. It's more important to enable the women to have access to good foods, and to have some idea of how simple it is to prepare good foods--that they don't have to be able to do fancy recipes and that kind of thing.That it's simple, and these foods are easily accessible, and very often they're cheaper than the other kinds of foods. This kind of message is never said to them in so many words; it's* *demonstrated* *through the use of food itself.*

> Denise: *I would say that it's--I'll probably sound like the first paragraph of a briefing note--that CPNP is a comprehensive prenatal nutrition program targeted to pregnant women who live in disadvantage, . . . and that it's federally funded, but the decisions are made provincially about how the funds will be allocated; and that the actual implementation is managed by communities.*

I had anticipated some "tension" to emerge in this area, partly the result of an earlier experience with the HSMM Executive Committee that caused me to question whether there were sensitivities in this area. I had contact with the Executive Committee in the process of developing my research proposal. At one point, I asked the Committee to review a draft of an Ethics Committee submission. The Committee Chair helpfully suggested that I change the title of my research from project from "A Case Study Of A Prenatal *Health Promotion* Program Based On Education, Community Participation, And Capacity Building," to "A Case Study Of A Prenatal *Nutrition* Program Based On Education, Community Participation, And Capacity Building." My advisor and I discussed the situation and I agreed to make the change based on our feeling that "education, community participation and capacity building" were, in fact, well-recognized health promotion strategies. Therefore, the concept of health promotion was stated implicitly in the new title of the research.

I had also heard from CPNP staff working in the National Office that the "N-word" in the name of the program had raised similar issues in other parts of the country. A staff member shared with me feedback that she received on more than one occasion from community groups: *"The only thing wrong with the Canada Prenatal Nutrition Program is the word "nutrition" in its title!"* (LM, personal communication, September 28/00).

This apparent source of "tension," and differing opinions related to whether HSMM has a nutrition focus or a more comprehensive health promotion focus (that includes nutrition), has been addressed in greater detail in subsequent chapters. It was important to raise the issue at this point in the thesis because it did partially explain the differing perspectives of participants and Key Informants on the goals and objectives of HSMM.

7.6.4. Identifying and Recruiting Partners

A critical strategy during Phase 3 involved enlisting the collaboration and strategic support of a wide range of partner agencies and organizations. This phase was described as "Planting the Seeds" because in order to recruit partners, the concept of HSMM had to first "germinate" in the community, and then flower into an "entity" that intrigued prospective partners and "fit" with their respective program priorities.

Victoria, a former employee of MARD, the sponsoring organization (now employed by Dietitians of Canada, the current sponsor of HSMM), recalled her initial involvement with HSMM. At this point in the interview, Victoria described the primary responsibilities of the sponsoring organization, emphasizing the issues related to liability:

> *I probably got involved at the community meeting, and I was there on one of my first days as staff of Manitoba Association of Registered Dietitians* [MARD]. *MARD had recently taken on the sponsorship of the Healthy Start program. I don't think it* [HSMM] *had a title at that point, and it was just a community meeting. I've stayed involved ever since, through the role as sponsor for the program, rather than a direct service role in any way. And since the time of sponsorship under MARD, there was an organization transition within the dietitians' community, so nowHSMM is under the sponsorship of Dietitians of Canada* [DC]. *I still represent the sponsor and look after the issues of liability. That's my main concern from the organizational point of view. DC underwrites all of the staff employment contracts, as well as any granting applications.*

Sarah contemplated the motivating factors behind the decisions of the partner organizations to contribute both staffing and resources to the initiative. She raised the following hypothesis:

> *Probably it's the opportunity to reach people that they haven't been able to reach through their own system or facility. So, The Family Health Centre, for example, being on the south side of Portage Avenue, and wanting to really connect with women on the north side, but it's like a natural barrier, and so women from this side aren't inclined to access that service. But, The Family Health Centre is able now to connect with a whole different 'target' population just through locating themselves with us* [HSMM] *and partnering with us and that kind of thing.*

After pausing for a minute or so, Sarah went on to describe why she felt the public health nursing "systems," both The City of Winnipeg and the Province of Manitoba, had agreed to "come on board" and why they had made such a significant contribution of staffing resources to the program:

> *And I think the same thing prenatally. Of course, there was no system in place for public health nurses to really have prenatal contact with women . . . that was a very randomized kind of thing, how they might hear about a pregnant woman who was at-risk in the community, so this has given a much more structured way for them to have access to lots and lots of women earlier--a lot earlier. Whereas they were catching the postnatal*[women] *before.*

Alison, a City of Winnipeg Public Health Nursing Manager and a member of the initial HSMM Steering Committee, discussed the reasons behind the City's decision to contribute public health nurses to the program:

> *Ellen, you must remember when we did the prenatal survey with the City of Winnipeg, and some of the findings on the prenatal survey said, and I always kept this in the back of my mind when were developing this. Nine hundred women were randomly chosen for the survey and consistently their response was: 'We want friendly, sort-of-not-in-the-doctor's-office, not classroom-oriented learning about prenatal health.' And those were some of the principles that were used to develop HSMM.*

Alison explained why both public health nursing systems (i.e., The City of Winnipeg and the Province of Manitoba) contributed nursing services to HSMM. The City Public Health Nurses provided services to the HSMM sites located in the inner-city neighbourhoods, and their provincial counterparts provided services to the HSMM sites situated in the suburban areas:

> *We had determined through a community consultation, which included clients that would use the service and also service providers and other stakeholders where the sites were going to be located in the city. A couple of the sites were in the provincial area for public health, in the suburbs, so there were provincial nurses, public health nurses, involved in those sites.*

Judy, a community dietitian and HSMM team member who participated on the original Steering Committee, was asked how the program determined who the critical partners were:

> *We knew what we wanted to do. We knew that there were certain partners that would be necessary: a dietitian, the public nurse and other partners that were in the communities. We knew that those pieces all were necessary parts of the programming. So it was really talking and talking about how it could come together and where in the city it could take place.*

Judy recalled the process of site selection, the significance of "natural geographic barriers" to the women's participation, and the reason why her employer (Inner-city Health centre) wanted to be affiliated with a HSMM site:

> Interviewer: *Was there was a lot of discussion about where the sites should be located?*
> Judy: *Yes. We went forward here from the Inner-city Health Centre* [with a site recommendation]. *We were not one of the initial sites considered, but we knew that people around here don't travel a lot, and transportation is a huge issue. People don't cross over the bridge to go further north for programming, and they really don't go much closer to Portage Avenue for services. So we felt it would be a benefit to have a program close to here.*

The program report submitted to Health Canada in 1996 included a recommendation to develop a site in the "inner city: south Logan area; (with dietitian-partner from the Inner-city Health Centre)" (HSMM, 1996, p. 13). Thus, Judy's wish, and that of her employer, became a reality.

Jane, a community health educator/nurse, and HSMM team member, described why her organization, and perhaps others, came "on board":

> *So it's how do we work as a community to support the women in the struggles that they're having? And it's not just The Family Health Centre* [Jane's employer] *that's feeling that way. There are ongoing discussions: there are a variety of different groups in the community who are looking at potential opportunities for the women in the community to come together to identify what they feel their needs are in terms of dealing with poverty, food security, children, all of those pieces that are part of their daily lives.*

Jane recalled the thinking behind her personal decision to get involved at a HSMM site and the very informal way that it came about:

> *The program at the Evergreen Community Centre started in May and I became involved about six months later at the invitation of the dietitian and the peer outreach worker because of my experience working in the community and my experience as a crisis worker. The women who were coming to HSMM often times were raising issues of a psychosocial nature around domestic abuse, histories of sexual abuse, other ongoing situations that they felt within the program perhaps they weren't meeting in the best way for the women. It's to have an additional person onsite who is already working in that field who might be able to add a bit more into the program. So, it was through my connection with the staff already that I came to the site. We had actually met prior to the Evergreen site starting, at information sessions, and then quite completely separate from Healthy Start, the three of us ended up taking Aboriginal awareness training together.*

A nursing manager (Kathleen), employed by an inner-city community health centre (The Wellness Centre) that donated both dietetic and nursing services to HSMM, described the nature of her involvement and explained the rationale behind her employer's ongoing commitment to HSMM:

> *I'm right now on the Steering Committee and a member of the Executive Committee, and had the opportunity to get involved right from the very beginning when Healthy Start was just an idea, and we* [staff at the Wellness Centre] *were asked to attend some initial meetings and see what this could be all about . . . to be part of the visioning. Right now, we have staff from our agency participate as regular staffing for some of the Healthy Start sites. We have a dietitian as well as prenatal nurses that attends one HSMM site regularly.*
> Interviewer: *What's behind the Wellness Centre's decision to contribute staffing to the degree that you are?*
> Kathleen: *It's a belief that it's a really valuable service, and it's reaching women that aren't necessarily attending facilities like ours. I think we're putting our resources where we're going to be able to maximize and do the most good work, so it seemed like a really worthwhile project . . . we thought it was important; it really was, and we tried to figure out a way to do it. Sometimes the women actually attend Healthy Start and come to The Wellness Centre, as well. We tell all of our new prenatal clients about Healthy Start, so we're encouraging the connection with both because they can meet different needs.*

Kathleen explained that The Wellness Centre had tried, on many occasions, to reach the HSMM target population with little success. She discussed openly the sense of frustration and discouragement when various programming efforts failed. Kathleen confirmed the success of HSMM in attracting and retaining high-risk pregnant women in unprecedented numbers:

> *In prenatal education, we've experimented over the years with many different types of education delivery, because one method never works for everybody. We've done the traditional classes that are six to eight weeks long; we've tried to have a prenatal day (a drop-in) as a component of prenatal education, we've tried to do the private one-on-one, we've tried evening classes, and they all have varied degrees of success, or lack thereof. I think that the format that Healthy Start is using is a different slant on things that we've tried, and it certainly does seem to be reaching a group of people that are attending regularly, always attracting new people, so it's working.*

The HSMM *"slant,"* or approach to programming that Kathleen referred to above, is discussed in greater detail in Chapter 4 describing the "Kitchen Table" approach.

7.6.5. Continuing Community Consultation

As the HSMM--Developmental Process (Appendix B) indicated, the community consultation process continued in Phase 3. A third half-day community consultation was organized by the Steering Committee in March 1996. The primary purpose of the meeting was to enlist the feedback of potential participant women/teens and representatives of stakeholder groups, on the resources under consideration for purchase. Close to 40 people participated in the process with the major outcome being "materials critiqued--highlighted practical, easy reading resources to be assessed by target women " (Healthy Start for Mom & Me, 1996, Appendix I).

A fourth community consultation took place in October 1996 involving 75 representatives. The goal of the meeting was to determine the location of the HSMM neighbourhood sites. The first step was to collaboratively identify the following requirements:

- Community centre facility accepted or perceived as non-threatening by potential participants
- Easy to get to with respect to public transportation and participants' sense of natural community boundaries
- Link to target population
- Place for children's care and activities
- Kitchen facility
- Year-round access
- Supportive philosophy and interest of host facility

- Volunteers would be an asset
- Reliable operational assistance (e.g., on-site custodian would be helpful; as would an agency coordinator)

> HSMM acknowledged that in some situations the program may need to assist a site in obtaining needed items such as furniture, toys, and cooking equipment (Healthy Start for Mom & Me, 1996, p. 13).

By the conclusion of the fourth community consultation, five to seven areas for drop-ins had been identified and targeted for start-up in the first year. Additionally, core-staffing components for each site were proposed. Four other suburban sites were identified that also required a program on account of "low income and other risk factors, and elevated low birthweight rates" (Healthy Start for Mom & Me, 1996, p. 13). Program documents stated that these sites would be targeted for development if other funds were obtained to enlarge the HSMM core staff.

7.6.6. Clarifying Roles and Responsibilities

The HSMM--Developmental Process flowchart (Appendix B) indicated that four HSMM core staff members were recruited and trained over an 18-month period, beginning in September 1996. Formal job descriptions were developed for a community dietitian/coordinator position, three peer outreach worker/counsellor positions, and one peer resources/office assistant position.

Additionally, the Program & Community Development Coordinator position was re-defined in January 1997. The new position, entitled Program Manager, reflected the fact that HSMM had become fully operational and that the incumbent was now responsible for a staff of five full-time employees and all aspects of program delivery. Sarah explained how the job had changed:

> *It's a completely different job, because it moved from development to management. What I have felt fortunate about mysel is that I have enough management experience to be able to take it from the one place to another. I know a number of people who are really good at one part. But not the other.*

A classified advertisement that appeared in the Winnipeg Free Press (September 2, 2000) outlined the knowledge, work experience, and interpersonal skills required of the HSMM manager. The advertisement was precipitated by Sarah's secondment to the Province of Manitoba (Department of Family Services) to "head up their prenatal and postnatal strategy (as yet un-named) under the Healthy Child Initiative." The advertisement, drafted by Sarah, and approved by the HSMM Executive Committee stated that

> We seek a caring and collaborative manager with the following qualifications and aptitudes: (1) non-profit management and experience (including financial, personnel, funding, etc,); (2) university degree and human service background; (3) demonstrated understanding of marginalization, community development, health determinants, nutrition, adult education principles, prenatal and postnatal concerns; (4) excellent team-building, communication and program development skills (5) a visionary who attends to the nuts and bolts with enthusiasm, humour and flexibility. (Winnipeg Free Press, 2000a)

My impression of the advertisement, based on my experience with HSMM, was that it accurately captured the competencies required. However, I recorded in my journal feelings of discouragement and some frustration thinking that it was highly unlikely that a dietitian would read the advertisement and apply for the position. It appeared that the gap between what was required and what the "typical" dietitian could offer the position had grown substantially wider since MARD originally advertised the position in 1995. It meant that nurses, social workers, occupational therapists, and other professionals with extensive community development experience would apply, but not dietitians. That was exactly what happened. (CE, personal communication, September 25, 2000.)

In Chapter 10, possible explanations are explored for the apparent deficiencies in dietitians' professional training and the narrow breadth of their work experience at the community level. These may also partly explain why dietitians did not apply for the position of HSMM manager.

Subsequent chapters describe and explain HSMM core staff roles and responsibilities through the experiences of the dietitian/coordinator, three peer outreach workers, and other members of the HSMM team. Additionally, orientation and ongoing training/continuing education requirements of staff and team members have been highlighted. However, staff roles and responsibilities were delineated in Phase 3 of the community organization process, as were the initial training requirements of both staff and community partners.

7.7. Section 2–Theoretical Constructs

Findings presented in Section 1 describe the community organization process between 1995 and 1997 that resulted in the design and implementation of HSMM's Collaboratve Outreach Model (Appendix C). The work mobilized individuals and organizations to build the capacity of the community for effective health and social improvement. Collaboration was fostered, and local empowerment realized, by "harvesting" community interest, talent, and resources. HSMM brought together professional and lay partners, government networks, and volunteers to plan and implement a community-based prenatal nutrition program.

Successful collaboration requires hard work, takes time to develop, and considerable attention to a myriad of details. According to Melaville et al. (1993), cited in Rosenthal (1998), "rather than proceeding in a linear fashion, the sequence of collaboration progress can be viewed as a 'slinky model' that "spirals and loops back to regain strength before moving ahead" (p. 12). Each phase is characterized by specific strategies, processes, challenges, and outcomes that require completion in order to move ahead. Community organizers involved with the design and implementation of HSMM learned that before advancing to the next phase, it is necessary to revisit and update knowledge gained in previous stages. Remaining flexible and open to the idea of incorporating new factors on a regular basis is paramount.

In the process of moving through the first three phases of the community organization process, these specific strategies were employed to accomplish the complex work: (a) securing a program sponsor, (b) selecting a lead organizer, (c) starting with the voices of participant women, (d) collecting community data, (e) achieving a common vision, (f) encouraging shared values, (g) choosing an organizational structure, (h) defining program goals and objectives, (i) identifying and recruiting partners, (j) clarifying roles and responsibilities, and (k) recruiting talented and committed staff and volunteers (Bracht, 1999; Labonte, 1994; McLeroy et al., 1988).

7.8. Summary

The major findings related to the first three phases of the community organization process are outlined in the Chapter Summary. Conclusions and recommendations pertaining to the research findings presented in Chapter 7 are addressed in Chapter 11.

7.8.1. Phase 1–"Preparing the Earth"

No one organization or sector acting alone has the necessary resources to significantly affect the changes needed to improve the health of a community. In the case of HSMM, those who shared an interest in prenatal health improvement came together to pursue their common goals. Impetus for the development of HSMM's Collaborative Outreach Model (Appendix C) was heightened by the increasing emphasis on health promotion; Health Canada's intention to allocate funding to a city-wide consortium rather than individual agencies; and a growing realization that local social, health, and economic issues affecting individuals and communities are often intertwined and compounded.

Leadership was repeatedly mentioned as the most important function of HSMM's effectiveness. Coalitions, like HSMM, by their very nature are complex and dynamic requiring skilled leaders to make them effective community organizing structures. It was serendipitous that HSMM's Program & Community Development Coordinator had the vision, knowledge, skills, personality attributes, and proven track-record in community development to bring the partners together and move the organization process forward. HSMM staff and community partners consistently described the one pre-requisite collaborative leadership style, as facilitative. Rather than directing the developmental process, Sarah focused on building the capacity of individuals and community partners to pursue a collaborative way of working that "leveled the playing field" and effectively managed diversity. The consensus-building approach employed by HSMM closely matched the "strengths-based, community-centred" typology to community organization described by Minkler and Wallerstein (1997) and illustrated in Figure 2.1.

Finally, the under-stated role of the funder was acknowledged as being very important, particularly during Phase 1 of the developmental process. The provision of the CPNP Guiding Principles and National Goals/Objectives set the stage for program development at the local level, without exerting undue influence or control. Health

Canada's willingness to allocate funds to allow the developmental process to unfold was significant as it provided the time necessary to build community support and reach consensus on the proposed model of service delivery. Additionally, the community organization process that gave birth to HSMM would not have been realized without adequate, sustained core funding from Health Canada.

7.8.2. Phase 2--"Planning the Garden"

It is now well accepted that effecting change on the broad determinants of prenatal health requires active participation and contributions from a wide range of stakeholders: all levels of government, professional associations, public health professionals, health care institutions, community-based agencies and lay organizations, academic institutions, the private sector and an extensive volunteer network. HSMM also acknowledged the critical importance of "starting with the voices of moms"(Labonte, 1994). Program staff and community partners demonstrated through their words, and their actions, how to sensitively and appropriately involve the recipients of services in the initial stages of the community organization process. HSMM's community empowerment approach viewed participant women as partners in the process of identifying and solving their own problems. This approach provided new models for professional-HSMM moms interactions and inspired confidence in the self-actualizing potential of participation.

The community analysis conducted during Phase 2 served as a basis for a plan of action and provided a benchmark for monitoring changes and evaluating effects. The emphasis of the analysis was on understanding the Winnipeg community better--how the community differs in health status and in its readiness and resources to change the health status of high-risk pregnant women and teens. The critical social science approach (Eakin et al., 1996) was concerned with assessing the community's needs, social structures, common values, and its capacity to support a city-wide prenatal nutrition program. The community consultation process in Phase 2 resulted in the early involvement of participant women and key organizations to build collaborative partnerships and facilitate broad community participation.

7.8.3. Phase 3–"Planting the Seeds"

Phase 3 demonstrates the importance of formalizing activities to mobilize community support starting with the establishment of an organizational structure. In the process of identifying and recruiting partners, The Working Group began to define the initiative's mission and goals. The roles and responsibilities of program staff, community partners, and volunteers were also envisioned at this time.

In developing the model for service delivery, it was recognized that successful programs targeting high-risk populations offer a broad spectrum of services. Social support, emotional support, and concrete assistance with other issues in the lives of participant women often take priority over prenatal care. Therefore, program structures must remain flexible and it was important to see the expectant women or teen within the context of her surroundings. This is consistent with a socio-environmental approach to health promotion (Labonte, 1994). The manager of HSMM, emphasized the many layers of life experience that participant women live with:

> These are gutsy women who also may have been wards of the child welfare system, abused as children, and now too probably, are streetwise including experience with prostitution and drugs, may live in desperate chaos with day-to-day crises and subsistence concerns governing their lives (Whylie, 2000, p. 26).

The community consultations conducted in Phases 2 and 3 confirmed that successful programs try to reduce the barriers of money, time, fragmentation of services, and geographical and psychological isolation that present "road blocks" for high-risk pregnant women and teens. Rather than waiting passively for participant women to negotiate around these blocks, program staff and community partners worked to reduce the barriers and the isolation of poverty. They were vigilant in their efforts to reach those that would benefit the most.

In the process of recruiting HSMM core program staff it was recognized that successful initiatives rely on skilled, highly committed individuals who often serve as role models for participant women. Effective programs create a culture that is founded on professionals and lay staff establishing respectful, caring, and trusting relationships with those they serve, as well as with each other. According to Schorr and Schoor (1989), the lessons of successful programs targeting high-risk populations are

> the nature of their services, the terms on which they are offered, the relationships with families, the essence of the programs themselves--all take their shape from the needs of those they serve rather than from the precepts, demands and boundaries set by professionalism and bureaucracies. (p. 259)

In conclusion, the first three phases of the community organization process described in Chapter 7 set the stage for coalition building and advocacy in HSMM--the focus of Chapter 8.

CHAPTER 8

COALITION BUILDING AND ADVOCACY IN HSMM

8.1. Introduction

This chapter deals with coalition building and advocacy in HSMM. The content focuses on the final two phases of community organization that resulted in the consolidation of the HSMM Collaborative Outreach Model (Appendix C) between 1998-2000. Phases 1-3 of the developmental process that occurred between 1995-1997 are addressed in the proceeding chapter. As discussed in Chapter 7, community organizing is a dynamic phenomenon. Thus, Phases 1-5 overlap to a certain degree and some of the tasks or key elements are repeated.

Chapter 8 is divided into two sections. Section 1 begins by defining coalitions and advocacy. The content in Section 1 describes two phases of the community organization process. Phase 4--"Nourishing and Maintaining the HSMM Garden" focuses on coalition building and advocacy in HSMM. Phase 5--"Sharing the Harvest" provides an overview of lessons learned over a five-year period. The section concludes with a discussion of the future challenges identified in interviews with HSMM staff, community partners, and Key Informants.

Section 2 summarizes the theoretical constructs pertaining to the research findings presented in Chapter 8. As in other chapters, The Empowerment Holosphere in HSMM is used as an organizing framework for the research findings presented in Chapter 8 (Figure 8.1). The "coalition building and advocacy" sphere links two "levels"--community organization, discussed in Chapter 7, and the sphere of "political action." To date, HSMM has not established a strong presence in the political arena. Thus, this "level" of The Empowerment Holosphere in HSMM is not addressed in detail. However, findings discussed in Section 1 of this chapter suggest that HSMM is well poised to take political action in the future. The chapter summary outlines the major research findings related to coalition building and advocacy in HSMM and links the findings to the theoretical constructs discussed in Section 2.

8.2. Section 1—An Overview of Coalition and Advocacy

8.2.1. Sphere of Coalition Building and Advocacy

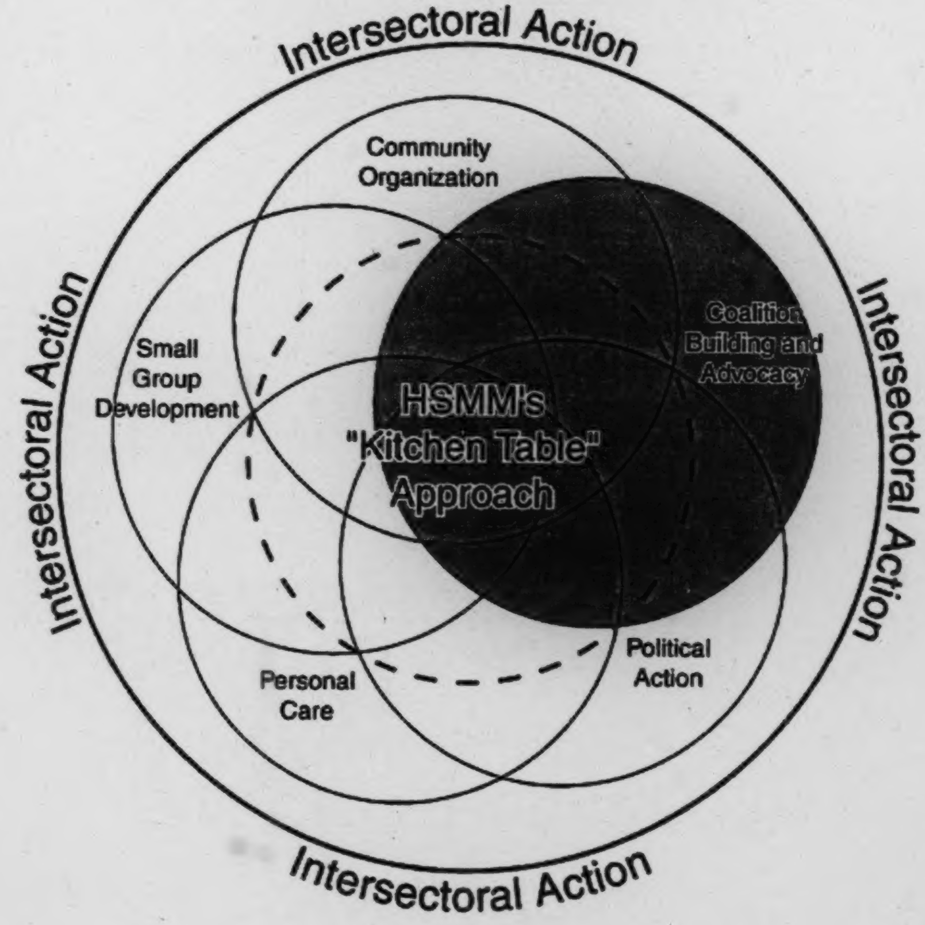

Intersectoral Action
Intersectoral Action
Intersectoral Action
Intersectoral Action
Community Organization
Small Group Development
HSMM's "Kitchen Table" Approach
Coalition Building and Advocacy
Personal Care
Political Action

Figure 8.1. The Empowerment Holosphere in HSMM (coalition building and advocacy).

8.2.2. Coalition Building and Advocacy Defined

The coalition--an alliance of several community groups and/or health organizations--has become an increasingly popular strategy for implementing community health promotion efforts (Bracht, 1999). According to Labonte (1994), coalition building and advocacy "are tonics to the [geographical and political] limitations of community organizing" (p. 76). A coalition has been defined as "an organization of individuals representing diverse organizations, factions or constituencies who agree to work together in order to achieve a common goal" (Feighery, Rogers, Thompson & Bracht, 1992, p. 1). Labonte (1994) defined advocacy as "taking a position on an issue--initiating actions in a deliberate attempt to influence private and public policy choices" (p. 76). In The Empowerment Holosphere (Labonte, 1994), coalition building and advocacy strategies are combined because successful advocacy efforts usually involve community-based coalitions. In practical terms, it is difficult to contain the discussion pertaining to advocacy in HSMM to Chapter 8. Research findings suggested that advocacy was integral to the roles of the Peer outreach worker and HSMM professional team members. Thus, the advocacy theme is also addressed in Chapters 6, 9, and 10.

Labonte (1994) clarified that there are two contrasting notions of advocacy. First, practitioners can advocate by taking a stand on public policy issues pertaining to health issues of concern to individual clients and/or the community-client. These could include social welfare reform, employment policies, or environmental standards. Second, practitioners can support community groups in their own advocacy efforts by "offering knowledge, analytical skills, and information on how the political and bureaucratic structures function" (p. 76). Labonte (1994) described this type of advocacy as an extension to practitioners' efforts in community organization.

8.3. Phase 4--"Nourishing and Maintaining the HSMM Garden"

Phase 4 describes the process of consolidating the HSMM program from 1998 to 2000. This phase of community organization process turned theories and ideas into action. In the process, HSMM's Collaborative Outreach Model (Appendix C) was translated into an operating program that was both effective and accountable. According to Bracht (1999), during the consolidation phase "community members and staff gain experience and success with the program" (p. 101).

Between 1998 and 2000, HSMM developed a solid foundation in the community, and the interventions gained "buy-in" among intersectoral partners. During Phase 4, the HSMM "garden" was nourished and maintained through a broad base of community networks. By the completion of Phase 4, community ownership of HSMM had taken place. This phase of community organization incorporated specific strategies to ensure that HSMM program was implemented effectively and efficiently. While much of this activity continued to be coordinated centrally, through the efforts of the Steering Committee and program manager, the HSMM interdisciplinary teams attached to community-based sites, began to assume a more significant role in program planning and implementation. The nature of the interactions between HSMM participant women, program staff, and community partners "attached" to two HSMM sites is described in detail in Chapter 4 to 7.

Throughout the interviews, HSMM staff, community partners, and key informants recalled challenges that they had encountered in a variety of areas as the program became fully operational, and the steps that were taken to resolve these issues. Section 2 focuses on specific examples, cited by interviewees, in which bureaucratic systems "had to bend" to accommodate the needs of the newly established HSMM coalition.

8.3.1. Generating Broad Community Participation

Throughout Phase 4 of the community organization process, a continuing effort was made to reach out to people and encourage their participation. As the program's visibility in the community increased, and the participation of women/teens continued to exceed expectations, the strength of HSMMs partnership base assumed paramount importance. Several members of the Steering Committee questioned whether it was necessary to formalize partnership arrangements at this phase of program implementation to ensure that the staffing support critical to the success of the program was in place.

Victoria, representing the sponsoring organization on the HSMM Steering Committee, expressed her feeling that it was timely to re-examine the terms and conditions of the partnership arrangements. Historically, the arrangements with partner agencies had tended to be informal, flexible, and based more on good will than any type of formal commitment. However, Victoria referred to community partners withdrawing services for legitimate reasons, often on very short notice, and the resulting hardships for the program in securing additional staffing resources. When asked how the program could be strengthened, Victoria replied that

> *from the point of view of running the program itself, more certainty and consistency of contributions from partners. Things change, and things are always going to change, but that means going out and finding another dietitian or bringing in other people on a temporary basis. It's ensuring that partners maintain that consistent commitment so that if you have someone who's gone off on maternity leave, there's some obligation on the part of the partner to do the replacement instead of program staff having to scramble.*

Victoria contemplated whether formalizing the partnership arrangements through "written documentation" of the terms and conditions (i.e., service level contracts) would be of assistance:

> *A lot of it is based on goodwill and discussion. Maybe there needs to be more documentation in terms of service agreements, or that kind of thing? Because staff within those partnering organizations change, and then the understandings that were made, agreed to, and accepted within that staffing change as well. Then you have to go back and re-build those bridges and say; 'There's history.' Whereas if there were some sort of documentation, you at least have something with which to work.*

Susan, a member of the HSMM Steering Committee, also questioned whether strengthening the partners' commitment to the program, and increasing the number of partners would alleviate staffing concerns. Susan and Victoria's comments underscore the significance of "formalized agreements" with partner agencies and organizations described in Building Partnerships for Health: Lessons Learned (Health Canada, 1998a). Susan raised the following question:

> *Perhaps even a stronger commitment from the partners, or having more partners? Perhaps that's more to the point, because I think there's a pretty strong commitment from the partners we've got. There just needs to be more, and a strong emphasis on the importance of their contribution to the program.*

Sarah, the Manager of HSMM, also expressed concern with respect to the fluctuating commitment of some partners. She specifically referred to ongoing challenges recruiting community dietitians, "attached" to local hospitals or community health centres. Sarah did not necessarily agree with Susan's suggestion to increase the number of partners and she provided this explanation for her position:

> *I know that Edmonton's experience was continuous increasing numbers* [of participants] *over the years. They increased the number of partner agencies, so they increased the number of outlets. We're more contained by our structure based on eight sites and a finite number of partners. And if the partner thing were to fluctuate any more than it does, it would be a problem. We had a Main Street Centre dietitian, and that changed, and The University Hospital's involvement has changed* [withdrawn], *and that creates stress in turn because we have to pick up the pieces on our own. And so the whole structure was predicated on partners, but the question is . . . what do you do if the partners can't stay involved? If the hospital says, 'We're stretched to our limit doing what we're already doing and we can't get out there in the community.'*

8.3.2. Maintaining a "Crop" of Community Dietitians

Victoria commented on the difficulties that HSMM experienced recruiting dietitians and suggested that some of the challenges might be the result of health care reform. She referred to the ongoing efforts to regionalize services under the direction of the newly established Winnipeg Health Authority (WHA). Victoria commented about how receptive the hospitals had been to be the idea of involving their dietitians in the HSMM program:

> *I think there's been some interest, and there's been a sense that they* [the hospitals] *would like to partner more. But Healthy Start is acting in the context of all kinds of health care reform, and Winnipeg has been in that storm for the last two years. I don't think that they* [the hospitals] *have been able to commit as much as they might have liked. I think they've gone through so many changes themselves . . . . Even within the WHA, the structure around maternal-child health--I don't think it's there yet. They're still looking internal to their walls. And the WCA is so busy trying to set up their own access centres . . . . Maybe eventually, when the dietitians are in place in the community-based access centres, they will be a key player but we're not there yet structurally.*

Victoria indicated that there was not yet an infrastructure in place to support the role of the dietitian in the community setting. This ongoing challenge to coalition building in HSMM is addressed in Chapter 10 focusing on the emerging role of the community dietitian. Nan echoed Victoria's concerns as she recalled the process that she used to try to encourage the participation of dietitians, often attached to local hospitals or community health clinics. She began by stating, *"We could have used twice as much* *dietetic input as we had."* Nan spoke of her efforts to market the program to dietitians, and clarified what she meant by *"pitching":*

> *I remember pitching HSMM to other dietitians; 'Who do I need to talk to in your organization?' I start with you, as the dietitian. Maybe you don't quite understand what we're doing out here. But I see you, and where you're geographically located in the city, and I see that we have a site in that area where we could desperately use a dietitian. So, I pick up the phone and call you. I ask, 'Would you be interested? How do you think the idea of your donating services to HSMM would be received in your organization?' And then I have to deal with the dietitian saying; 'How can you even ask that when we've been stripped back to such and so'. Then, I say, 'Listen, let's have this conversation.' And then you and I talk together--a nice, healthy conversation. But, I challenge the view that you're serving your community from within the hospital. It was a time when healthcare was restructuring, and they*[hospital staff] *were terribly, terribly threatened--not threatened by us--threatened that they would lose positions. But, I still tried. When I say pitching, I mean selling--selling the idea that there's a role for you, a hospital-based dietitian, with HSMM..*

8.3.3. "Nourishing the HSMM Garden"

There were many stories describing the collaborative efforts to "nourish and maintain" the HSMM "garden" over the past five years. One story specifically relates to the Evergreen Community Centre HSMM site. It demonstrated "how" and "why" partner agencies, in this example the City Of Winnipeg Parks & Recreation Department, came "on board." The partnership has resulted in a welcoming, supportive, and "nourishing" environment for HSMM team members and participant women involved with the Evergreen Community Centre site.

The story began to unfold in an interview with a HSMM team member (Jane) as I listened to her describe the support that HSMM had received from the Parks & Recreation staff at the Evergreen Community Centre site:

> *I know that the staff at the community centre* [Evergreen Community Centre] *are so pleased and very supportive of HSMM when they see the number of women coming to the site. And it certainly enabled the staff at Evergreen to essentially bend over backwards to provide more services for this particular group in the community. They're open to; 'What other things do women want to do? Do they want to do a community kitchen? Do they want to do this? What can we do to help that?' So, I think that the HSMM program coming into the Centre--attracting women to this site--has given hope to the community, and a recognition of potential.*

Jane explained that the Evergreen Community Centre had not been successful in drawing community residents to the site. However, the situation had recently improved with the recruitment of a Facility Supervisor (Ralph) who approached recreation programming in an innovative manner. As Jane talked about the Evergreen Community Centre, and its interest in expanding programming to meet the needs of women living in the area, it became increasingly obvious that the Facilitator Supervisor (Ralph) should be interviewed. Ralph began by describing his position with the Evergreen Community Centre:

> *I've been with Recreation Services with the City of Winnipeg for the past seventeen years as a recreation technician. My portfolio right now includes the Evergreen Community Centre. I'm the facility supervisor and responsible for children, youth, and adult programming. I've been at this site for six months.*

Ralph concurred with Jane that HSMM had been very successful in bringing neighbourhood women into the facility, many of whom were coming for the first time.

> Ralph: *HSMM was such a drawing card. . . . It was the first time that I ever saw women coming to this facility!*
> *Interviewer: In the six months you'd been there?*
> Ralph: *Yes, . . . and there was nothing in the past. I checked records, and there was no adult programming, and that was a concern to me. I see the children, and I see the youth, so there had to be some sort of mother or parent attached to that. This facility is in a very awkward position. It's not attached to any catchments--no school or any buildings that are close by. So you really have to struggle to get people to come here. But once they've seen it, they're very impressed with the site.*

The interviewer asked Ralph to describe the relationship between HSMM and Parks & Recreation staff at the time he arrived on site:

> *The only association HSMM had with the City of Winnipeg Recreation Services was, basically they had a facility. They had a room, and there was no personal touch to that, nor was there a personal face to that, so they didn't even know who the supervisor was prior to my starting. I worked with the staff to break down that barrier and broke some paradigms down to say, 'This is who we are. How can we help you to make this program a little more successful?'*

Ralph discussed why it was important to establish a closer relationship with the HSMM team. He referred to the process as "an overhaul," and outlined his staff's efforts to work more collaboratively. Ralph's comments are significant because they emphasize the evolving cooperation between two sectors--health and recreation/fitness:

> *All I did, I think, was an overhaul. What I wanted to see at this facility was to make sure that Parks and Recreation staff had a little bit more input and a little bit better relationship with any user group . . . that we were seen as more than just 'renters' of the facility to groups. So what that took was our staff caring a little more about the details--what HSMM requirements were in regards to how they wanted their setup of chairs, mats, kitchen facilities, dishwashing detergents to clean their dishes. We started applying our efforts that way--that we can make their job a lot easier if we did a little prep work prior to them arriving here.*

In the process of conducting on-site participant observation, I had noticed attractive relatively new sofas in the room where the drop-in took place, and I had asked the HSMM staff if the sofas belonged to them. The staff told me that they had discussed with Ralph their desire for sofas to give the room more of an-home feeling, as opposed to just a space. Ralph described what happened next:

> *I saw these women breastfeeding, sitting on little plastic chairs. It looked really uncomfortable. I saw them really moving around in the chairs trying to get comfortable . . . . I thought, maybe we can remove those chairs and get something a little more comfortable . . . that would allow the moms to socialize a bit more. All it took was a phone call and passing the word around and they were donated. We also put up screens so they can have a little more privacy while they're conducting their business.*

Ralph was asked if this new way of working had presented bureaucratic challenges for him, realizing that he was part of a complex city system with a reputation of being very slow to new ideas or innovations. He suggested that he had learned how to make the system work and provided a concrete example:

> *We used to have forms that they had to fill out, and I really got away from that process, because I couldn't believe that a form would stop people from coming to the site. Not only Healthy Start, but also other groups as well. HSMM staff, they're like family here, and if they need a day, they can just go write in that book and write down the day that they need and the hour that they need, and they don't have to give me a reason why they want it--they'll just receive it.*

In the above quotation, Ralph implied that he placed a high priority on developing relationships between the HSMM team members. According to Bracht (1999), this is a key criterion for developing effective coalitions because it enhances trust and respect between partners. In response to a question asking Ralph what advice he could offer other agencies/organizations interested in working collaboratively, he stressed the need to be flexible and accommodating and to remain open-minded:

> *You definitely have to be really open-minded. I think that the red tape has to definitely be cut out, especially in asking for a lot of written stuff. I think you have to stay away from that. Ask them what their needs are, and just go day-by-day and improve on that. I think to ask them for long-term goals, to ask them to get reports ready prior to giving them the facility, I think it really stops the process. It sets them up for failure. I think that the efforts have to be in drawing the women to the Centre more than writing reports.*

Ralph enthusiastically described his ongoing support for the HSMM program and its overwhelming success in attracting women to the Evergreen Community Centre site:

> *It's the first time in my seventeen years that I heard about it* [HSMM]. *And it's a shame because it's such a great program. Yesterday for example, when HSMM was here, I saw easily forty moms on-site. It was incredible! I was really impressed. What's real is that I see forty women come through that door every second week, and I see it on a continual basis . . . not only forty women, but also new ones all the time. I don't know exactly how HSMM is doing it, but it's working. It's really working, and I want to be part of that. I really want to make sure I can do anything so they can continue--give them a safe atmosphere here, and clean, and help them out that way. The children are benefiting and the youth are benefiting from HSMM. I think it's a legacy that will be left for a long time.*

8.3.4. Providing a System for Monitoring Feedback

HSMM has worked consistently, in collaboration with the CPNP National Office, and the HSMM Evaluation Sub-committee, on the selection of criteria to measure the effectiveness of programming. HSMM has developed and implemented data collection methods and protocols for both process and outcome measures. Under the guidance of the HSMM Evaluation Sub-committee, program staff and community partners have attempted to develop evaluation plans reflecting the needs of participant women, available resources (i.e., time and money), and, the capacity of the program to implement and sustain evaluation activities. Process or formative evaluations assisted HSMM in reassessing strategies that have worked, and those that have experienced difficulty and should be revised or abandoned.

Throughout the interview process, program participants and key informants described their experiences in implementing both process and outcome evaluations. I also had ample opportunity to observe program staff "in action" as they worked to collect the required evaluation data in a sensitive and unobtrusive manner. Some interviewees maintained that HSMM had already proved itself, based on the program's overwhelming success in attracting and retaining women. Given the heavy workloads, demanding nature of the work, and the ever-increasing numbers of participants, some team members appeared to question whether the evaluation activities were worth the time and effort. Or perhaps, staff wondered whether the national evaluation would tell them anything that they did not already know? In observing program staff and community partners involved in their day-to-day work, I made a journal entry: "tail wagging the dog?" meaning that, on occasion, while in the field, I wondered whether the significant evaluation efforts were worth it?

Throughout the interview process, program staff and HSMM team members referred to both the art and science of evaluation research and the challenges related to "making it work" at a community level. Participants described their experiences with evaluation that were integral to the community organization work involved in "nourishing and maintaining" the program. It is important to understand the context of evaluation, through the experiences of those involved with the HSMM.

Denise, a manager in the CPNP National Office, with lead responsibility for the national evaluation, discussed what has been learned to date, and what the policy implications may be down the road:

> *We're at a point where we can talk about the implementation--what we've learned about implementing this kind of program. We can talk about the ways that we have very successfully attracted the population that we felt might need a program like this. We can talk about broadening the partnership base, about community access, about spin-off activities, and the in-kind support. And we certainly have numbers now that we can draw some conclusions about the target population. For instance, we're seeing a lot of teens coming and a lot of teens smoking and a lot of teens having a second or a third child, and so from that we're seeing there are policy implications for Health Canada and for programmers across the country. What we still, I think, are maybe reluctant to conclude is how much difference we're making with birth weight.*

Denise went on to describe the evaluation data that the CPNP National Office hoped to capture and she shared formative plans to expand the current national evaluation strategy:

> *And so we have some information, but we're hoping to add questions about how the woman is feeling or what changes she's felt, and how she's ready to care for a baby, or how connected she feels to the community and how she's doing maybe cutting down the smoking, or does she have a supporter? We need to collect more, we want to collect more information . . . . I don't think that we'd be going beyond our mandate by asking a few more questions that will then, I think, give us some really useful information about the differences that CPNP is making in the lives of the women and in the community.*

Denise discussed frankly the political pressures related to evaluation and the reality that politicians and program staff may not always see "outcomes" in the same way. She identified the pressure to prove cost effectiveness and work that the National Office was contemplating in this regard:

> *The piece that we're going to work on next, or we want to do some really good soul searching about, is the cost effectiveness because that was in the back of the politicians' minds back in 1994. And that's, I think, how we were able to move onto the political agenda because deficit, deficit, deficit was the word of the day. And so to be able to implement something very nice like apple pies and babies, and at the same time respond to the deficit. This is the politicians' dream. Now we need to go back and spend some time this year looking at birth weights and the cost of supporting a disadvantaged infant versus the cost of building a program across the country and looking at whether there might be other ways of delivering CPNP services that are more cost effective.*

Denise's comments reinforced the fact that past budget deficits, fears of wasting tax dollars and perpetuating dependency, and a pessimistic view of social problems being "un-fixable" have all contributed to politicians' increasing demands for tangible proof of effectiveness as a condition of support for any health or social program.

In response to a general question on program evaluation, Nan pragmatically stated that one of the significant outcome measures was the increasing number of participant women attending HSMM:

> *How would you know if you're being successful? One of the first things is, can you mobilize these women, can you get them out, and are they participating in the program? We went from a program that didn't exist, in a city where I don't know the stats, but we know that the participation rate in the traditional prenatal*

> *services--like classes--was very low, to having with the first two years, three hundred participants and now its up to five* [hundred] *or whatever. Knowing that women are coming out, that they're coming back, and that they're describing HSMM in their own terms as a success, as something that meets their needs, and as something that is very helpful to them.*

Sarah appeared a little hesitant to "get into" the topic of evaluation. This hesitation may have had something to do with the national CPNP evaluation, and the pressures placed on individual projects to "quantify" both program input and outcomes. Sarah described, in her words, the goals of the national CPNP evaluation:

> *There is an external evaluation process with Health Canada that is trying on a countrywide basis to create--and more or less doing it--an apparatus to be able to collect from right across Canada a sense of impact. But, what it is in fact doing, in my mind, is really describing the profile of people that we attract to the program and some impacts I would walk cautiously with, the low birth weight impact, for example. There is, I guess, starting to be some evidence, if our numbers are correct and our data are working well, which would indicate that some of the low birth weight rates might be coming down. But, I'm very cautious.*

Listening to Sarah, I was struck by the fact that her perception of the national evaluation, and what had been learned to date, was very close to what Denise had shared. Sarah went on to explain what might be missing from the national evaluation, and why that was cause for concern:

> *There isn't a kind of qualitative piece in that Health Canada part, and so it's kind of quasi research, but it's not research, because it's all self-administered surveys. All of our program people are responsible for getting data in, and we all know that we can taint the data. And I'm not saying that anyone's suspicious about that, but I think it has its limitations potentially later if you look at it too much as a research base.*

Sarah's comments on the national evaluation suggested that the current methods of demonstrating effectiveness were not capturing the essential "extra dimension" that characterized successful programs, like HSMM. In her view, how the services were delivered was as important as the fact that they were delivered. Sarah's comments were consistent with Labonte's (1993) vision of a community development approach to program planning. Labonte (1993) maintained that "goals and objectives emerge through the process" and that the emergent learnings are not "unintended outcomes"; they are the plan (p. 36). According to Labonte (1993), quantitative approaches are utilized when appropriate, but much of the evaluation relies upon qualitative measures (p. 36).

In response to a question asking if the participant women were involved in the national evaluation, Sarah replied:

> *In the sense that they answer questions on forms, yes. But it's not the way you and I might think was ideal. I'd be interested in what you call participant research, where the participant women help structure what the questions are, what they want to know, and that kind of thing. That's something down the line.*

Sarah's response called for a new approach to community-based research that is based on a mutually respectful partnership between researchers and communities. She suggested that the CPNP research protocols could be improved by incorporating the knowledge, expertise, and resources of involved community members. Sarah expressed an interest in learning more about participatory approaches to research that maximized community and lay involvement. Sarah's suggestion that CPNP collect and analyze both qualitative and quantitative data to be used for action as well as evaluation purposes is consistent with the recommendation of Israel et al. (1994).

Sarah recalled that initially HSMM really struggled with the national evaluation:

> Interviewer: *Initially, it felt pretty foreign?*
> Sarah: *Yes, because it's such a scientific, clinical kind of approach to programs that are self-describing as something different than that, and so it was hard to make it fit. Most of us have adjusted and do the very best that we can to provide as much as we can. But, we do still think that we lose some women because we ask them too much information too soon, and that that's threatening. And, the other thing that it's not capturing is the kind of stuff that you're capturing: What do women think of the program? What makes them come? Why do they stay? What have they got out of it?*

She then described specific "pieces" of information that appeared to be missing in the CPNP national evaluation framework (Appendix A):

> *Things like, 'How did you hear about the program?' and 'Did you try some of the recipes at home, taste new foods?' 'Cut down smoking?' Because the really obvious thing missed in the national evaluation is, they ask people if they smoke; they don't ask them if they have cut down. And, that's one of the national goals.*

Sarah stated that the HSMM Sub-committee had included these "pieces" in the evaluation protocol for the Winnipeg-based program. The Sub-committee had also included several questions attempting to ascertain the extent to which HSMM participants experienced food insecurity.

In discussing the topic of evaluation with Sarah, she explained that HSMM is continuously attempting to capture information from participant women to help staff improve the program:

> *One of the ways that we try to keep track is just to keep up continuous dialogue with moms so that we learn if we're doing things right or wrong, or whatnot. There's another idea that the staff and I have talked about. It's really basic, probably a one-time thing to do with some groups of women where we would get them to tell us really basic things like; 'What kitchen utensils do you have in your kitchen?' We found out that some women weren't redeeming their juice coupons because they didn't have a juice pitcher. We got a bunch of pitchers from The Buck Store and let those go as draw prizes. But it makes you realize that it's important* *not* *to assume that women have a knife, a cutting board, and a pot . . . It keeps you sensitive to what cooking utensils you're suggesting, or what else you need to bring into the program as practical resources to give-away.*

Denise described a National Office goal for the coming year that involved enlisting the support of "CPNP Champions" who could assist in translating the evaluation findings, and "lessons learned" into languages that diverse audiences could easily understand. One of the tasks of the "Champions" involved defining "comprehensive programming" using CPNP "stories" from across the country:

> *One of the goals of our program this year is to interest or support more champions to CPNP--healthcare providers, more people working in population health and determinants of health, to talk about what CPNP is doing, the contribution that it's making, but through the eyes and ears of the group they represent. That's how more people will understand that comprehensive programming in a community and a setting that is right for participants works so much better than addressing a single issue in a setting that's not set up for that issue, or for that person.*

Building Partnerships for Health: Lessons Learned (Health Canada, 1998a) highlights the role of a champion in sustaining intersectoral partnerships. The authors concurred with Denise, when they stated that "even the best intersectoral agreements can languish if there are no internal champions who will hold their organizations accountable. The importance of having a passionate commitment to the issues cannot be overemphasized" (p. 18).

8.3.5. Establishing a Positive Organizational Climate

A positive climate is a critical factor in promoting and maintaining successful community-based interventions. According to Bracht (1999), "a positive environment fosters cooperation, improves retention of staff and volunteers, and sets the stage for the development of community ownership" (p. 101). Successful collaborations are based on

> *good group process, developed and nurtured through an attitude of trust and openness. Staff must demonstrate trust-earning behaviours, including respect and discretion. In a positive organizational environment, people look for opportunities rather than roadblocks and for strengths rather than weaknesses in one another. Mistakes are used as learning opportunities and conflicts are resolved quickly and opening. (p. 102)*

HSMM's organizational climate has been discussed in other chapters that describe the nature of the interactions between participant women, program staff, and community partners. Two stories are important to tell at this point because they raised fundamental "issues" that had the potential to seriously undermine the coalition building process.

The first story began to emerge during he interview with Alison, a City Of Winnipeg nursing manager, who had "lead" responsibility for the public health nurses involved with HSMM. In the process of describing some of the systemic challenges relating to negotiating successful partnerships, Alison reflected on an issue that proved problematic in the early days of implementing the HSMM Collaborative Outreach Model (Appendix C). The issues, raised by the public health nurses, related to the new Personal Health Information act (PHIA) and the nurses' responsibilities in complying with the legislation:

> *There were concerns about whether public health nurses should be sharing confidential "client" information with the rest of the HSMM team . . . . There was a misunderstanding that PHIA said; 'No way can you share anything with anybody.' That was a misunderstanding of the act, and it was resolved with education with the nurses that what the act really says is that 'you need to share information appropriately with other caregivers.'*
> Interviewer: *And it would be the nurses' professional decision as to how to do that, when they do that, etc.*
> Alison: *Right. And the only time that you not do that is if the client-participant indicated that they did not want you to give that information. And then the act, however, goes on to say that if you think it's going to be harmful to that person or others* [not to disclose the information], *like in STDs, then you need to . . . .*

> Interviewer: *So these are really concrete examples of how working in these interdisciplinary teams is challenging, and that no sooner do you think you've got something figured out than something else comes along.*
> Alison: *Yes. And the assumptions that we make of each other.*

Alison proceeded to describe a second "issue." This story related to a HSMM participant woman's decision not to breastfeed and the potential for other team members to misinterpret this decision, and in particular, the nurse's role in supporting the woman with her decision:

> *The assumption is that you're not supportive, or you don't want people to breast feed.That one just keeps coming up because that was a common issue. That was not it at all. There were lots of other reasons. For example, the nurse would go to visit the client in her home . . . the mom's got two other little ones, and she's trying to breast feed this one, and the two-year-old's hanging out the window, and she just can't handle it. It's just too much. She's totally stressed out, and this is after the public health nurse has supported her, tried everything . . . given her all types of alternatives. The mom was just too stressed out.*
> Interviewer: *And the baby would be doing better on formula?*
> Alison: *Yes. The whole family would be doing better. It became the issue of the whole family and not just one child out of the whole family.*
> Interviewer: *And the nurse was in a better position to assess that? Because she had developed a relationship with the client in the home, away from the drop-in session?*
> Alison: *Exactly. Sometimes, that caused a little bit of conflict in thinking we weren't supportive* [of breastfeeding], *that Public Health was not supportive.*

Sarah also spoke at length about the challenges to maintaining an open, trusting, and positive environment and suggested some possible next steps for the HSMM Steering Committee to consider, in consultation with community partners. One suggestion called for a written agreement clarifying "surface principles" (i.e., program goals, means and norms). Sarah raised the following question:

> *How can we--I think its better when it comes from people themselves--capture what some of our values are? We can call them surface principles or something, so that we then have some kind of document, simple, I hope, not like a policy, but a document that can be something that's shared--a shared language or a shared perception--so if you run into problems down the line with partners perceiving things or wanting to behave or treat something really, really differently, than you perhaps have a place where you can come back to and say, 'Let's look at this. Okay, we've agreed we're going to try to be woman-centred in how we deliver the program and follow up with her in the community.'*
> Interviewer: *What does that mean?*

> Sarah: *We sort of get to the point of, okay, for example, you notice that there's issues that you think are really serious. Do you do it the old way? Do you come out of the old way, which is behind her back, calling the professionals or Child and Family Services or medical people, and do a front-end assault on her? Or, do you work with mom and say, 'We really have some concerns. We know that you're trying to do the best with your baby. There's some things that really need to be talked about, and we want to talk about it with you.'*
> Interviewer: *Who is the we? It's not an individual professional any more?*
> Sarah: *No, that's right.*
> Interviewer: *It's now Healthy Start?*
> Sarah: *That's right. So, we've knitted something together and in the process have come up with something else. Even though people do have mandates in other areas. There's a blurring of the boundaries--like Healthy Start itself--we've come to a new territory, a new place .So the question is, 'How does a dietitian, or a public health nurse, carry out what she feels is her rightful piece of this, but in conjunction with the mother, and with the others on her team, and with the agency that that they have responsibility for?'*

Sarah's suggestion that HSMM develop a document clarifying *"surface principles"* is consistent with a recommendation included in "Terms of Authentic Partnerships" (Panet-Raymond, 1992, cited in Labonte, 1993). The authors called for "written agreements…clarifying objectives, responsibilities, means and norms." They stated that "regular evaluation allows adjustments to these agreements" (p. 83).

8.4. Phase 5–"Harvesting the Stories"

The importance of coalition building and advocacy in promoting health is increasingly recognized (Labonte, 1994). Some of the lessons learned through the process of designing, implementing, and consolidating HSMM between 1995 and 2000 are shared below. The lessons reflect what was said by program staff, community partners, and Key Informants in individual interviews. A caution expressed earlier in the thesis, related to the methodology, needs to be repeated. Interviewees were pondering their experiences over a five-year time frame that involved considerable systemic change and re-organization. On occasion, interviewees' recollections of events and processes were vague and lacked specificity of time and person. Thus, not all stories were explored by the researcher equally. Some interviews gave rise to very rich constellations of insights pertaining to lessons learned, while others did not.

Interviewees tended to describe lessons learned from two perspectives. First, they spoke of collective learning related to the community organization process and the impact of HSMM on the broader community. Second, they described personal learning and growth that they had experienced as a direct result of their involvement in HSMM. In this section, the lessons learned have been limited to those that specifically relate to participants' experience of the community organization process. Subsequent chapters address lessons learned that specifically relate to one of the other major themes.

8.4.1. Messages of Hope

Jane, a nurse/educator on the HSMM team described how the program had planted a seed of hope in the community:

> *There really hasn't been, to my knowledge, a program of this nature that has done so well, and I think that speaks to the program and to the people doing the program. HSMM has shown other agencies within the community the potential that exists at a time when you can feel discouraged. Often times the small steps feel like you're going backwards and not forwards.*

Kathleen also spoke about a message of hope related to the program's overwhelming success in connecting with a previously "un-reached" high-risk population:

> *Healthy Start certainly complements other programs that are out there working with the same target population and goes one step further to add what traditional service providers maybe couldn't provide or couldn't connect with. In terms of the community as a whole, it really has had a positive influence. If you can have a healthier baby, and a healthier mom, and a healthier parent, society as a whole benefits from that in the long-term. And if you can give people a good start, or a better start than they may have had, the benefits just build on each other. I think that HSMM certainly made a difference to this community. Some of those women wouldn't have gone elsewhere, or they might have gone, but wouldn't have got the degree of support or service. Or, they may not have chosen to talk about issues because they didn't feel safe, and I think they do with HSMM.*

Nan described why she felt such a strong connection with the program and a growing sense of optimism related to the impact of HSMM on the broader community:

> *I like HSMM because I think it stands a chance of breaking a cycle of poverty and of pushing on the larger systems. I would say that it is a program that gives me hope. I don't think that HSMM can do it alone, and I don't think that 'health'* [the health sector] *will ever do it alone. I think HSMM takes a woman's life and*

> *throws it into a much broader dimension. So, I like the way that the program has the potential to knock down stovepipes and bring people together from the education system, the justice system, and that all of these systems are working together at the community level. I like that, and I think we need to see a heck of a lot more of it.*

8.4.2. It Works--HSMM Works!

Sarah stated that the fact that HSMM "has worked" is a valuable lesson, in and of itself. She explained this concept further in a series of separate thoughts, and for the first time I heard the HSMM model of service delivery aptly described as "a moveable feast": *"One impact has been the model itself of sites, neighbourhood teams, drop-in, . . . a 'moveable feast.' People are interested in that. HSMM has also challenged people's assumptions that 'this population' won't participate in finding solutions to community problems."* Sarah described the interest that other agencies and organizations had expressed in understanding *"what makes HSMM work."* Sarah explained that was a very difficult question to answer, and that there really were not any "prescriptions" for success:

> *Some groups seem starved to hear the really practical things that we do--like what works, what doesn't work, how we've learned to tackle this kind of subject . . . or, just looking at the little games and activities that the staff have developed. It's as if people who are interested in reaching low-income populations or the quotes, hard-to-reach--we don't use that phrase so much any more--but don't know how to do it. There aren't prescriptions for what we do, so even though you say, 'Okay, here's how we used this envelope with words in it, and people draw these words out of the envelope,' it's still not something that you can easily transfer into an environment like a classroom and expect it to work the same. If you don't also have some of the other ingredients happening--where it feels friendly, where people are wearing jeans, where you've got food, easy come, easy go--so it's a real mixture of many different ingredients.*

Sarah expressed concern that other agencies and organizations might "pick up" one component of the HSMM model and "parachute" it into another community-based program, expecting it to work. She used peer outreach as an example:

> *I think seeing other agencies pick up on peer workers is one* [area of concern]. *Not all may be equally aware of the kind of support, and time commitment, that you need to build in to be effective in supporting peer workers in new roles in the community. It's not always an easy path. If peer staff are constantly hearing the issues that they've already faced in their own lives, they can despair or drown in*

> *it. So, where agencies think that it* [peer staff] *are almost like a quick solution and/or a cheaper solution, I think that they do it at their peril.*

8.4.3. Strengthening Partnerships

Kathleen spoke about the community organization process and the opportunity to strengthen new and existing partnerships in the community:

> *The more opportunity you have to meet with other groups and work with them side-by-side, the more you will hopefully develop better bonds and stronger relationships. For example, with the public health nurses in the neighbourhood, although they've changed some, and my staff have changed some, they're developing better working relationships . . . for myself personally, I've met many other women that I may not have had the opportunity to meet and that's enriched what I can do too.*

Sarah expressed her feeling that community partners thought that HSMM made their jobs easier. However, she questioned whether the partner agencies and organizations fully appreciated all of the work that HSMM put into keeping the program "on track":

> *I think that there are a few* [partners] *that might see that HSMM makes their job easy, which I think we do. And, we know that they couldn't do it on their own--none of us could do it on our own. We all need each other. But I think that the background logistics to all of this miraculously set up a kind of over arching tent* [infrastructure] . . . *Having all this happen is a lot more work probably than a lot of people are aware. But I think they appreciate it. It's the same--we don't know all the details that go into their jobs the rest of the time either.*

Sarah re-stated this concept another way, using the words of a community partner: *"This is great! We get to be involved in a great program, reach the people we're supposed to, and you guys do all the details of making it work."*

Alison commented that the community organization process had challenged health care professionals' knowledge and understanding of community development. She differentiated between a traditional "community-based" approach to community development and the "community-paced" approach used by HSMM. Her comments echoed those of Labonte's (1993). He maintained that allowing individuals and groups to identify their own health issues and concerns is one of the most important axioms of an empowering health promotion practice. He suggested that most agencies work from a community-based, rather than a community development perspective, and in doing so "make invisible the power differences that characterize community group/institutional relations"(p. 36).

> *The process that was used to develop the program and implement the program was very much a community-development approach. The principle of ensuring that the participant was involved throughout the decision-making about the program design was a real learning experience. I think, for the broader community on how to do that, especially for professionals, who say that they've worked in community-based programs. This was more than just a community-based program; this was community driven in its approach because the decisions, the model, even how the resources were picked, the location of the sites, all of those things, had input from participant women and all of the other stakeholders as well. So, the success of the implementation of HSMM really was, I think, a huge learning experience for the broader community.*

Alison described how HSMM avoided the political "land mines" and the program's success in eliminating "turf" issues between agencies and organizations with a history of professional rivalries and competition:

> *I think that the other impact it had on the broader community is that HSMM was able to bring together agencies and sectors that would probably have never come together before to address an issue. I think it's because the approach was, 'We're here for this issue, so what's the best way of addressing this issue? So, let's forget about our territories, our turfs.' Everyone had a stake in it, and everybody's strengths contributed to making it happen; and the ownership didn't go to any one agency, but went back to the participants. So, I think that some of those principles really helped to make it more inclusive, and I believe that was another learning experience for the broader community.*

Alison, as well as other participants, discussed the learning acquired through the community organization process that convincingly demonstrated that it was possible to build on existing systems rather than constantly starting "from scratch":

> *I think we learned that we could build on existing systems; we can look at where the gaps are and strengthen those. That it's not always necessary to build something new or to develop parallel systems. This is a good model to illustrate that, because I think we get caught up in thinking that things always have to be new. Instead of developing a parallel system, we looked at what each partner could offer, and how those services were linked. For example, public health nursing receives all of the birth notices, so we were able to share that information instead of Healthy Start having to try to get it.*

Susan, Chair of the HSMM Steering Committee, described HSMM's potential to enhance or complement existing services as a key motivating factor in bringing partners "on board":

> *I would hope that the way other organizations and partners would look at it was--Yes, this is something we should be doing, and here's a wonderful opportunity. We don't have to set up the superstructure; we don't have to set up the system; it's already there. All we have to do is assign this to one of our staff members, and we're fulfilling part of our mandate. I would hope that they would look at it this way.*

Alison suggested that HSMM's use of interdisciplinary teams and collaborative way of working, raised issues and perhaps tensions for professional staff. According to Alison, the issues related to the need to "let go of our professionalism" and that for some HSMM team members this was very threatening. Her comments reflected the observations of Drevdahl (1995) who stated: "Many nurses and other health care providers assume that their education provides them with appropriate leadership positions in the community. This assumption may in fact become a barrier in fostering community empowerment" (p. 20).

Alison expressed surprise that the nurses struggled with this issue to the extent that they did:

> *I think that the big 'piece' for health and social services professionals was, 'How do we as professionals let go of our professionalism? How do we share some of our knowledge with, say, the paraprofessional, and the participants, without feeling threatened?' I'll be honest with you. I thought that the public health nurses were ready to work in integrated service delivery models . . . . I thought; Oh yes, they're ready for this, but they weren't. Because when we brought the teams together, all of a sudden it was, 'I used to provide that nutrition service. I used to talk about labor and delivery, and breast feeding . . . and now we've got a nutritionist to do that.' Even though it's a resource that the nurses always asked for* [a nutritionist] *. . . a resource that they thought they needed more of. Everyone had to figure out his or her roles. And everyone had to figure out what is their strength that they were bringing to that team and what their roles were going to be. That was a huge learning experience for the public health nurses because when you're talking about integrated service delivery models, that's what it means: 'It means being able to provide service in a continuous way that the participant doesn't even know what is happening.'*

The "turf" issues that Alison raised in the above quotation were critical to the effective functioning of HSMM's interdisciplinary teams. They are discussed in greater depth in Chapter 10.

8.4.4. Importance of an Ongoing Recruitment Plan

While turnover of program staff and community partners is to be expected in multiyear projects, the HSMM Steering Committee had identified the importance of counteracting this with a plan to identify, recruit, and involve new people in the project on an ongoing basis. Interviewees appreciated that new sources of energy and commitment can be helpful to volunteers who may be experiencing some "burnout" characteristics.

Victoria discussed the need to re-look at the governance issue, specifically the roles and responsibilities of the HSMM Steering Committee. Susan stated that it was important and timely to re-involve participant women on the Committee. Susan and Victoria recognized that HSMM must be vigilant in ensuring that community participation was "real," and not "symbolic." Minkler (1997) cautioned that even when programs committed to community participation through advisory boards and other processes, there was a tendency to ignore input and resort to paternalistic actions because of predetermined plans, funding guidelines, priorities and timelines. Victoria stated that

> *The initial HSMM Steering Committee was self-selected and was enormous; I think it was something like thirty-five people. It gradually diminished in size to the point where now it's really not much more than the Executive Committee. This is a whole area of governance that we need to look into and re-establish. The moms dropped off the Steering Committee because they got jobs, which is good news, but not helpful to the Committee. We really haven't replaced them, so we've been remiss in that. I think we really need to re-establish the Steering Committee and get the representation from the moms. And we're aware of that.*

A tool developed by Herbert and Irene Rubin (1992) would assist the HSMM Steering Committee in assessing whether ongoing community participation was "real," or "symbolic." The DARE criteria of empowerment raises the following questions: "Who determines the goals of HSMM?; Who acts to achieve them?; Who receives the benefits of the actions?, and; Who evaluates the actions?" (p. 77). Victoria and Susan both appreciated that the active involvement of the community in all stages of program implementation and evaluation was necessary to ensure that HSMM sustained authentic community participation and empowerment.

Victoria described why she felt it was necessary to re-examine the issue of project sponsorship. She raised some questions that the Steering Committee hoped to address:

> *We're also looking at the much broader issue of sponsorship; should HSMM become a separate, legally established organization--a charitable organization--so that we can accept financial contributions? We know that it has to be broader than it is at the moment, but how broad should this be? There is a whole range of issues out there that we need to look at.*

In referring to the idea of an ongoing recruitment plan, Victoria and Susan expressed concern that the Program Manager might one day leave HSMM for other employment opportunities. They appreciated that Sarah's leadership was an important function of coalition effectiveness (Bracht, 1999). In Susan's words:

> *One of the critical things in this program, and one of the keys to its success is the personality and the capability of the manager. And her knowledge of the community, of community services . . . her connections in the community are amazing. She is able to work with budgets; she's able to work with staff and with people; and she's so committed to the whole program. She works evenings and weekends and I don't know how she does it. Something that sometimes concerns me is that very often the success of a program like this depends upon one person with a tremendous amount of ability, drive, and commitment. Sarah, of course, is that person, and what if she left?*

Victoria shared Susan's concern and she attempted to answer the question that Susan had raised:

> *The answer, I think comes back to resources, because what you really need is to do some grooming within the program to allow for that absence which is inevitable at some point, to be filled with somebody equally committed, dedicated, and grounded in those principles. And I think that there's at least one person within the program, probably several, who have the potential, but they're so busy. Planning for that kind of transition is very important, because it's going to have to happen sooner or later; we hope it's later. That's a key piece that again I don't think is being addressed. The program is wrapped so tightly that there isn't the opportunity, really, to do that grooming and development, and that is a very scary thing.*

8.4.5. Stories of Personal Learning

Jane stated that her participation in HSMM had taught her the importance of not making assumptions, and of remaining non-judgmental, especially when working with participants of a different ethnic background. Her comments are consistent with the views of Wallerstein and Sanchez-Merki (1994) who stated that the co-learner role of the health educator is important. The authors described the power dynamics that permeate most relationships between health educators and community members, whether because of expertise, or because professionals often come from a different social class or ethnic group than their target population:

> *I think it's also made me more aware or perhaps reminded me of how, as people working in the community, regardless of what profession or what background we're coming from, to never lose sight of the community that we're working with and to remain open and non-judgmental, to ensure that you're checking out what your interpretation of a situation is rather than acting on that based on your values, that you take a broader picture and explore. I guess because it's a large Aboriginal population I've encountered some situations where perhaps there isn't a process for determining that. And I've heard women accused of abandoning their children if they have left their children with their family, which is a very traditional, acceptable cultural practice; and yet still in our society, I think that falls into a category of bad parenting. And to make sure that everyone has a comprehension of the cultural pieces that come into parenting and not to be putting our own values on misinterpretation.*

In response to a question relating to lessons learned, Denise stated that her experience with the development and implementation of the CPNP nationally had reminded her of the importance of starting with what people want to know, as opposed to what you think that they need to know:

> *Someone gave me the advice that content was ten percent and presentation was ninety percent. And in a way, I think that this principle is also true for CPNP and for community-based programming. There's nothing that can replace good, solid information about looking after yourself and caring for a baby and preparing for pregnancy, and most of us can get that on our own from reading a good book. But for our population, the ninety percent, the presentation, and the way it's presented is so important--it really is key. So I guess what I've learned about the value of presentation and the value of connecting with people at their level, and how you can, I think, probably make anyone understand, or help them to understand and work with them to do almost anything if you approach it in a way that is useful for them.*

Kathleen stated that her involvement with HSMM had caused her to reflect on the limitations of traditional approaches to professional training and how ill- prepared most professionals are to function effectively in a setting like HSMM. This notion is described in depth in Chapter 6:

> *It's reinforced that traditional, by-the-book things that we learn in school aren't always practical and realistic. You always have to be open to trying new things, you have to be patient as new ideas don't take off right away, but that doesn't mean that they're failures. You always have to be checking things out with people you're wanting to work with and don't make assumptions. This is a really good example of doing things with clients, right from the beginning, so that the ideas developed with them, because of them, because they believed it should be this way, not because a group of service providers got together and decided what needs to be done now and did it.*

Sarah contemplated her lessons learned as our interview came to an end. She commented on the importance of timing--being at the right place at the right time--and the fact that sometimes there is simply a *"synchronicity that works"*:

> *It sounds trite, but it's almost like 'where there's a will, there's a way.' This has been a dream job in a sense, just the opportunity to work from theory to practice on involving the community and listening and putting together the ingredients and being glad to have a funder that will let you fund things like milk coupons or bus tickets, whereas there would be other funders that would never go for that. You can completely miss the boat by overlooking something simple like that. So in describing it, I guess, one learning is that it's just wonderful when there's a synchronicity that works, when the ducks line up in a row, or when the timing is right. There are moments in time when I feel like I was really lucky to come in at a moment when there was a readiness in the community and we were all ready together.*

8.4.6. Dreams for the Future

Several HSMM participants and key informants spoke of their dreams for the future. These dreams shared many similar threads, as the following quotations illustrate. The idea of a common dream began to emerge in the interview with Mr. Holt, the elected official in the NDP government, who described his interest in developing what he called a *"culture of care"* as opposed to *"a set of rigid programs,"* starting with prenatal care and continuing until school entry. Mr. Holt spoke of studying the 50-year old French maternal and child health care system (protection maternelle et infantile--PMI), and his plan to visit France for a first-hand look at the program in September 2000.

Mr. Holt provided additional material on the PMI that described in detail the "culture" or "continuum of care" that Mr. Holt had alluded to in an earlier conversation. A report published by the French-American Foundation (Richardson,1995) stated that

> *for nearly half a century, France . . . has given national priority to women of childbearing age and children under the age of six. This priority involves and shapes major policies and programs in health and medical insurance, child care and education, and family allowances. . . . Founded after World War 11 to combat infant mortality and morbidity, PMI marked the critical passage of French child and family policy from 'charity for the poor to protection for all.' Over the years, PMI broadened its scope to emphasize health promotion through preventive care, family education, and early assistance to women, children, and families at risk of impaired health or development due to sociomedical factors. (p. 4)*

Denise, a senior program officer in the CPNP National Office described her dream for the future in language that caused me to reflect, again, on my conversation with Mr. Holt. Denise's dream, on a smaller scale than Mr. Holt's, referred to a continuum of prenatal-postnatal-early childhood care that would build on the federally funded programming that was already in place in every province and each territory of Canada:

> Interviewer: *It's building on the relationship that's developed prenatally and starting to address some of the postpartum issues?*
> Denise: *That's right, and as we collect more information, or feel more confident in what we can report about the woman's health, and where she is with respect to her lifestyle choices, or how ready she is to move on. What we would really like to see, I think, is CPNP and then moving into CAPC* (Canadian Action Program For Children) *and Aboriginal Headstart.*
> Interviewer: *A continuum of services, right?*
> Denise: *That's right.*

Denise's and Mr. Holt's dreams for the future suggested that it was possible to move beyond a fragmented collection of programs and services to a universal and seamless system of preventive care that assists all Canadian children in reaching their true potential.

8.5. Future Challenges

One of the "worry areas" that Sarah described related to the overwhelming success of HSMM in attracting participants to the sites on a consistent basis:

> *This year we'll be triple what we projected, and maybe more, and we don't know when it's going to stop. And because at this point the resources are finite for the program until we know what else is coming, so that we have to manage the program with a constant kind of dollar, so it doesn't give you the flexibility to add extra staff.*

Sarah related the steps that HSMM had taken to try to cope with this situation. However, she noted that HSMM was based on a founding principle that stated "no waiting lists" and "open to all":

> *Where it feels appropriate, we're saying to women, 'If this doesn't meet your needs or feels too crowded, you can go to this place or that place.' But what seems to be happening is that they want to come to HSMM. Many women love the big groups. Interestingly, shy women prefer a larger group because they can disappear in it. They've heard about HSMM through their friends that they feel comfortable. And remember, we said, "no waiting lists; continuous entry' and all that? Living up to that is proving interesting.*

Sarah described the possible options that were under consideration, but it was obvious that none of them were palatable either to her or to the other members of the HSMM Steering Committee. She indicated that HSMM's process evaluation results suggested that the increasing numbers were not detracting from the moms' positive experience of the program:

> *What are you going to do? Turn women away? But as soon as you start turning them away, you start getting a different reputation. Women have told us, 'I like coming to HSMM because there's no waiting lists. I feel mmediately welcome.' You know what: It's working. Women don't perceive that it's too busy. They think it's nice--even 'relaxed' some women tell us--they think it's organized, and they don't know you're surprised when thirty women show up. I don't know . . . . I think we'll have to go back to participant women and say, 'What should we do here? What do you think?'*

Alison also expressed concern over the increasing numbers of participants and the stresses they placed on the program. Alison agreed with Sarah, that the idea of limiting participation by women/teens did not "feel right":

> *I think one of the things is that we didn't have a limit on the number of women coming. In some situations, we didn't have the resources to really accommodate the number of participants. I still hear from nurses that it's too hectic at the drop-ins. You can do the 'group thing', but there's no time for anything individual. And then the debriefing piece at the end needed to be streamlined, because you can't debrief on every mom when you have so many.*

When asked whether putting limits on the number of women participating in HSMM was the answer, Alison replied:

> *That's so difficult because women are not coming just for the milk coupons. They're coming for the experience, the sharing, the sense that someone cares . . . And it's an opportunity to get out of your home and meet other people, because they're so isolated. So, I think that the answer is that we need more supports and more resources put into it, early, early, early. If we do anything, we should be doing it earlier. It's early prevention--that seed at that time is what's going to make a difference in the long-term for that mom, child, and family. It's more resources and supports like HSMM that are necessary.*

At the time of Sarah's interview, she appeared preoccupied by HSMM's pressing need for additional resources. However, when she returned her transcript to me approximately four weeks later she added a postscript indicating that she was thrilled to hear that Health Canada had agreed to give HSMM additional resources:

> *You need to feel there's somewhere you can go to help you deal with what all this means. We could use an extra outreach worker for sure, and I think we're extremely cost-effective. I don't know what other CPNP projects across the country cost, but I'm sure if you looked at it on a 'per-woman unit', HSMM would be doing very wel. But, that's not always what your funder is able to respond to, so it's tricky. So then it falls back to us at the management level to figure out, what are we going to do here? And we don't want to burn out our staff or our teams. And an interesting thing is that now, if ten women show up at a site, there's a bit of a feeling of a slump if the week before there were twenty-five, instead of in the 'old days' when the teams thought ten women was wonderful--a nice number.*
>
> *Postscript . . . New info: Renewal funds will allow for adding in what we need to manage what we have (without expanding). Health Canada has taken into account the potential burnout factor and is willing to help with the infrastructure to help prevent the overload.*

Denise, a manager in the CPNP National Office was aware of HSMM's challenges resulting from the ever-increasing number of participants. She stressed the importance of the program taking that information back to the Joint Management

Committee (JMC). Denise suggested that, in the future, provincial governments would be asked to consider providing additional funding support:

> *I hope that that kind of information is constantly on the agenda of the Joint Management Committees, because I think that the province needs to step back and look at things. I know some individual projects have taken it upon themselves to do some screening. And whether that's a good idea or not, I don't know. We have to do some thinking about that, and take the information back to their management teams and JMCs. This year, in particular, we're able to address it with new funds. But, I think that CPNP can't do it all.*

8.6. Political Action in HSMM

As stated in the chapter introduction, research findings indicated that HSMM staff and community partners have not yet moved into the political arena. However, there were emerging signs suggesting that HSMM team members and community partners have taken small steps in this direction. The following section discusses the limited research findings pertaining to political advocacy in HSMM, and raises questions about future action in this regard.

Interviewees were asked to comment on whether HSMM's increasing visibility in the community and its broadening partnership base had effected policy change. Alison stated that, in her opinion, it was too early to expect an impact at that level. She questioned whether senior policy makers and elected officials understood the program and the principles on which it was based:

> *It's too early. To be honest, I think people think it* [HSMM] *is great, but I think policy makers don't understand it. And, I think that it's frightening for them because they don't have control. That's where I give Health Canada credit, because they've been able to give the funding . . . there's accountability; there always have to be accountabilities, but it's what shapes those accountabilities take. The program has to account for every dollar that it spends, but it's the way that it's done.*

Susan thought that there was, at a minimum, some awareness of the program within government circles, but she was not sure how much. Her comments describe HSMM's early efforts to move into the sphere of political action:

> *I hope there's some learning going on in government circles on this. I did have an opportunity to talk to the NDP Task Force about a year and a half ago. So, I obviously brought the program to their attention. So, I think that there is some knowledge of it within current government circles, and certainly, we've talked about it with people who are now sitting on the government side of the legislature, and they're quite aware of it. Now, whether they understand the basic principles or not . . .*

Mr. Holt, a senior elected official in the Manitoba legislature, was asked if there was anything about HSMM that had really captured his interest or attention. He replied; *"No, not really"* and proceeded to explain:

> *I've been involved in prenatal-postpartum-early childhood policy issues since the Maternal and Child Health Task Force in Manitoba at the Social Planning Council started in 1978 or 1979. It spent over half a million dollars over a five-year period and essentially said all of the things that Healthy Start for Mom & Me say. . . . We know from the work of the Montreal Diet Dispensary and from the knowledge of women from the time babies have been born, which is a fairly long time now, that nutrition and pre- and postnatal care--nurturing--is the way that people become people. And so I think the thing that's frustrating for me is that we've known these things for a long, long time, and governments have persisted in running pilot projects or sectoral projects when you're dealing with this sector or this age instead of a holistic view of a continuum of a whole child in the context of a whole family in the context of a whole community. We've known that's the way to go for a long, long time and we're just kind of taking baby steps towards it.*

Mr. Holt concluded his answer by saying; *"I think it's a great program, and I think it's a good initiative, but the only thing that's really surprising to me is how long it's taken us to get there."*

Later on in the interview, Mr. Holt was asked whether programs like HSMM had an advocacy role and if so, what should that be? He replied:

> *What we're talking about is the problem of poverty, and I think that anybody who's involved in a program ought to be advocating on behalf of their recipients and ought to be using research and using evaluation in order to shed light on what's keeping the program from reaching a higher level of effectiveness, or what's making it not work at all.*

Mr. Holt stated that programs like HSMM should be tied into wider poverty networks that are not as dependent as HSMM on government funding. He questioned whether HSMM was a member of Campaign 2000, and other antipoverty coalitions, that *"do a* *pretty good job of telling the story and being strong advocates."* Further, in the above quotation he emphasized the importance of research in generating "hard data" to prove program effectiveness.

Recent developments suggest that political attention provincially and nationally is focused on the emerging story of HSMM. First, in September 2000, HSMM's program manager was seconded to the Department of Family Services and Housing. Sarah was asked to lead a new province-wide initiative related to prenatal and early childhood development. Second, in August 2000, HSMM was highlighted in a keynote presentation at the International Congress of Dietetics held in Edinburgh, Scotland. The purpose of the presentation was "to share the Canadian experience in the delivery of a nation-wide prenatal nutrition program (CPNP) and to demonstrate how CPNP challenges the emerging role of the dietitian" (Matheson & Wylie, 2000, p. 1). As the national and international community became aware of HSMM's success in connecting with what had been described as a "hard to reach" population, staff received numerous invitations to share lessons learned with others. Third, Health Canada expressed interest in the case study research on HSMM. The researcher was asked to work with CPNP evaluation consultants to position the findings within the context of the comprehensive CPNP national evaluation framework. The case study research on HSMM will eventually be included in an evaluation report to be submitted to Treasury Board in 2001.

8.7. Section 2–Theoretical Constructs

A new type of coalition, exemplified by HSMM, highlights the policy advocacy potential of professional organizations. In Labonte's (1994) view, this potential is largely untapped and may enhance the advocacy efforts of organizations employing healthcare practitioners. In agreeing to sponsor HSMM, the Boards of the Manitoba Association of Registered Dietitians (MARD) and Dietitians of Canada took a position on prenatal health promotion advocating for more equitable, accessible, and sustainable forms of health and social programs. According to Labonte, (1994), "an organized voice of caring [and trusted] professionals" (p. 77) may be a very effective change agent in relation to how various levels of governments currently enact programs and policies.

The ecological model for health promotion (McLeroy et al., 1998) defined community factors "as relationships among organizations, institutions, and informal networks within defined boundaries" (p. 355). The authors pointed out that in the health field, there is often competition between community organizations and agencies for limited resources including government funding, volunteers, and media attention. Health promotion programming tends to be delivered through existing community-based agencies and organizations. Thus, McLeroy et al. (1998) argued that increasing coordination and collaboration among community organizations is instrumental in "influencing community awareness, local health policies, and resource expenditures" (p. 364).

To a certain degree, coalition building involves empowerment at the "level" of small group development (Labonte, 1994). This is because individual representatives of member groups must learn how to share power in order to support the collective goals of the coalition. According to Labonte (1994),

> Because coalitions often represent a direct politicization of an issue, member groups have learn to set aside both the complexities of their concerns and the differences in priorities and political analyses that often exist between them. (p. 77)

Labonte (1994) maintained that it was necessary for groups to move from conflict to consensus if they were to significantly influence and alter public policies and political decision-making.

Grey (1989), cited in Labonte (1993), described a comprehensive collaboration model for building and maintaining coalitions. In her view, successful coalition building has five main features:

> (a) enhanced recognition of stakeholder interdependence, (b) differences are dealt with constructively, (c) joint ownership of decisions is developed,
> (d) stakeholders assume collective responsibility for 'managing the problem domain' through formal and informal agreements, and (e) the process is accepted as continually emergent. (p. 80)

The author emphasized the importance of a "pre-negotiation" stage to successful collaboration that involved identifying the common ground between stakeholders prior to bringing them to the negotiation table. This step called on the efforts of "midwives"--

community developers who were functionally distant from all of the stakeholders--working with stakeholders in advance of formal meetings to discuss the overarching goal of the initiative. Chapter 8 describes the community development coordinator's role in the pre-negotiation stage of coalition building in HSMM.

The coalition building model described by Gray (1989), reflects many of the insights documented in Building Partnerships for Health: Lessons Learned (Health Canada, 1998a). The federal government publication recognized the importance of intersectoral partnerships in creating healthy public policy. The content highlighted the importance of developing plans for securing partners' ownership and involvement in follow-up action. The authors stated that partners must make explicit their intentions to follow through. They recommended a formalized agreement including the following elements:

> A framework for time commitment, action and accountability; commitment to share information on how each partner is implementing its actions; a mechanism for collecting and distributing information on follow up actions; and a single point responsible for monitoring follow up. (p. 18)

Carlyn and Bracht (1995) reviewed the literature on coalition effectiveness and identified the following functions important to overall coalition productivity: leadership; management; communication; conflict resolution; perception of fairness; shared decision-making; and perceived benefits versus costs (p. 96). Of these functions, leadership was considered to be the most important for coalition effectiveness. According to Bracht (1990), "coalitions by their nature are complex and fragile identities. Skilled leaders are required to make them effective organizing structures" (p. 95).

Butterfoss et al. (1993) stated that funding sources have responded positively to the use of coalitions as an intervention to address health issues. However, the literature suggests that coalitions have not been systematically studied and there is little data to date to support their effectiveness. According to Butterfoss et al. (1993), participants will consider joining a coalition only if the anticipated benefits outweigh the costs that are entailed. Potential benefits include: networking opportunities, access to information and resources, personal recognition, skill enhancement, and a sense of contribution in addressing community problems. Costs to joining a coalition include; contribution of time required, lack of skills or resources needed for participation, and "burn out."

Community leaders can use their understanding of perceived costs to develop appropriate incentives for participation.

8.8. Summary

The research findings described in Phase 4--"Nourishing and Maintaining the HSMM Garden"--reinforce the notion that successful coalition development and advocacy require openness in approach and mutual respect for different practices and perspectives (Bracht, 1999). Because HSMM represented a shared power structure, participation required consensus building and negotiation around most decisions (Labonte, 1994). Organizational representatives are generally not accustomed to sharing power and responsibilities, thus, new norms and cultures in HSMM provided a context for working collectively.

Interviewees described finding ways to adapt or circumvent traditional professional and bureaucratic systems when necessary to meet the needs of participant women and the collective needs of the HSMM partnership. Team members moved outside their own professional settings to provide services in nontraditional settings often using nontraditional approaches. Program staff and community partners spoke of redefining their roles to respond to the significant, sometimes unarticulated, needs of the target population. This phenomenon is described in detail in Chapter 10.

HSMM management, team members, and CPNP National Office staff identified issues related to program evaluation. Interviewees were aware of the fact that pressures to quantify can have a paralyzing effect on the development of new and innovative programs designed to reach high-risk populations. Current models appear to be looking at the topic of evaluation through new lenses. Judgment about what works is increasingly based on a thoughtful appraisal of the many kinds of evidence available. This means relying not just on quantitative but also qualitative information reflecting the experiences and understandings of committed practitioners and the program participants. Interviewees emphasized the importance of developing better ways to document the effects of complex, multi-faceted interventions on outcomes of interest to policy makers, program administrators, and funders.

Issues identified in Phase 5--"Harvesting the Stories"--reinforced the importance of celebrating and recognizing group success. According to Bracht (1998), the celebration of short- and long-term accomplishments, and the recognition of participants, is important in developing community ownership. Within HSMM, disseminating information on project activities and early evaluation results increased visibility, community involvement, and a sense of pride in the initiative. Maintaining high visibility is considered to be necessary to program sustainability (Bracht, 1998).

When funds are scarce, or resources limited, there may be pressures to focus on individual components of a successful program, losing sight that it was the sum of the parts that accounted for the demonstrated success (Schorr & Schorr, 1989). Additionally, well-meaning attempts to replicate a successful program elsewhere, using a rigid "cookie cutter" approach, is a surefire recipe for failure. Research findings highlighted that HSMM, like other programs serving high-risk communities, has some unique attributes, involve complex human relations, and do not lend themselves to mass production.

In Phase 5 of the community organization process, program staff and community partners described how their assumptions have been challenged and new insights gained. They expressed increasing confidence in the fact that key components of HSMM--"peer outreach, food and genuine acceptance"--truly work in connecting with what formerly was described as a "hard-to-reach" population (Matheson & Wylie, 2000, p. 31). Based on HSMM's success in attracting and retaining participant moms, program staff now refer to the HSMM population as "previously un-reached." A future challenge identified by interviewees related to the capacities of team members to cope with the ever-increasing number of participant women attending the drop-in sessions and with limited program resources.

Finally, research findings indicated that HSMM has not played a significant role to date in policy advocacy and policy development activities. Public advocacy would take the form of "encouraging citizen participation in the political process--including voting and lobbying, organizing coalitions to support health policy related issues, and monitoring policy implementation at the federal, state [provincial], and local level" (McLeroy et al., 1988, p. 366). Some indication was obtained that HSMM staff and community partners are poised for political action, however, it is not possible to predict at this point whether or not it will come to fruition.

CHAPTER 9

INTERDISCIPLINARY COLLABORATION IN HSMM

9.1. Introduction

As in preceding chapters, Chapter 9 is divided into two sections. Section 1 deals with interdisciplinary collaboration in HSMM as a process of development and change. The discussion is limited to two of a total of eight HSMM neighbourhood-based teams. Section 1 begins with a definition of "intersectoral action"--a term used to describe the individual and collective practices of HSMM team members. The content of Section 1 is on the experiences of team members attached to two HSMM sites--The Evergreen Community Centre site and the Willow Community Centre site. The nature of the interactions among program staff and staff contributed from partner agencies and organizations are explicated.

The issues and tensions emerging from HSMM's emphasis on interdisciplinary teams are addressed in Section 1, including the peer outreach workers' practices with marginalized women and their families. The ways in which interdisciplinary collaboration has challenged the norms and values of health professionals' practices is described. Team members' understandings of prenatal health promotion are discussed, emphasizing the lessons learned as a result of their participation in HSMM. The experiences of HSMM team members and key informants revealed in interviews are elaborated upon using field notes, historical documents, and other artifacts. HSMM team members' recollections have been expanded upon using the researcher's memories and personal experiences of the prenatal nutrition program between 1995 and 1997.

The chapter topic--Interdisciplinary Collaboration--overlaps to some extent with two other major themes, identified in other chapters, relating to the work of the HSMM team. Chapter 6 addresses the role of the peer outreach worker as a trusted bridge between professional staff and participant women. Chapter 10 describes the new and evolving role of the community dietitian within the HSMM program. In order to avoid duplication, the content presented in Section 1 of Chapter 9 is generally restricted to a description of the interaction between the members of the interdisciplinary HSMM team, the nature of the team relationship, and the interconnections between team members' respective areas of responsibility.

Section 2 summarizes the theoretical constructs underpinning the research findings discussed in Chapter 9. The Empowerment Holosphere in HSMM is the organizing framework for the case study research on HSMM. In Figure 9.1, the practices of HSMM's interdisciplinary team members are encompassed within Intersectoral Action--the outer ring of the Holosphere. The interdisciplinary practices discussed in Section 1 of Chapter 9 include health promotion strategies and approaches represented in all five spheres of The Empowerment Holosphere in HSMM.

The chapter summary highlights the major research findings related to interdisciplinary collaboration within HSMM, and links the findings to the theoretical constructs identified in Section 2.

9.2. Section 1–An Overview of the HSMM Teams

9.2.1 Sphere of Intersectoral Action

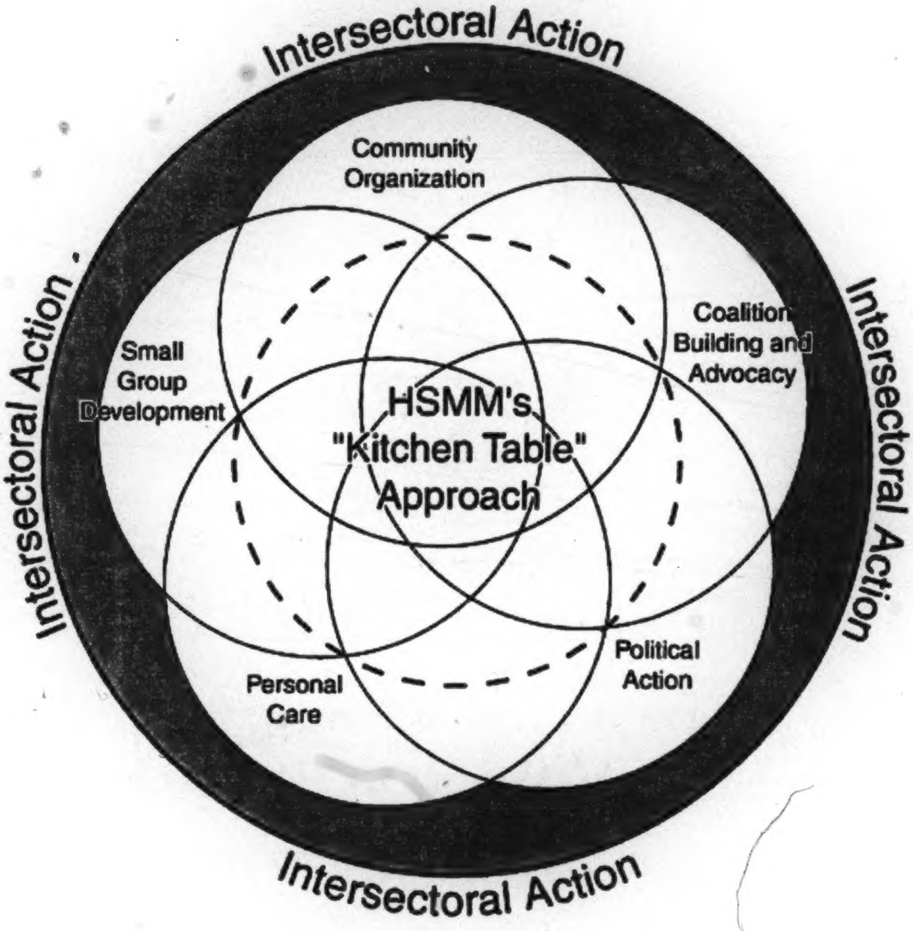

Intersectoral Action
Intersectoral Action
Intersectoral Action
Intersectoral Action
Community Organization
Small Group Development
Coalition Building and Advocacy
HSMM's "Kitchen Table" Approach
Personal Care
Political Action

Figure 9.1. The Empowerment Holosphere in HSMM (intersectoral action).

9.2.2. Definition of Intersectoral Action

The authors of the Report of the Federal/Provincial/Territorial (F/P/T) Advisory Committee on Population Health (1999a), defined intersectoral action for health as

> a recognized relationship between part or parts of the health sector with parts or parts of another sector which has been formed to take action on an issue to achieve health outcomes . . . in a way that is more effective, efficient, or sustainable than could be achieved by the health sector acting alone. (WHO International Conference on Intersectoral Action for Health, 1997, p. 8)

According to the F/P/T Committee on Population Health (1999a), intersectoral action can be both a strategy and a process. It is often implemented through community organizing activities including "advocacy, legislation, community projects, policy and program action" (p. 8). Intersectoral action typically takes the form of cooperative initiatives, alliances, coalitions, or partnerships.

Intersectoral action has two dimensions: a horizontal dimension that links sectors at the community level. These sectors could include (a) public partners in the health, education, social services, justice, and recreation sectors; (b) voluntary partners; and (c) the private sector. Establishing horizontal collaboration across sectors, and also across different areas or "sub sectors" within a particular sector (i.e., community nutrition and public health nursing; acute care and public health) requires building stable interdisciplinary teams that work well together and have the necessary supports. A vertical dimension links different levels within each sector (e.g., local, provincial, and federal government partners within the health sector). Both dimensions are important for success because they facilitate the "joining of forces, knowledge, and means to understand complex issues whose solutions lie outside the capacity and responsibility of a single sector" (F/P/T Committee on Population Health, 1999a, p. 5).

An examination of intersectoral action in HSMM reveals functions that are consistent with the community organizing process (Chapter 7) and coalition building and advocacy (Chapter 8). For example, intersectoral action includes: "needs assessment, identification and involvement of key players, citizen involvement, clarification of values and purposes, development of objectives, planning, budgeting, and evaluation of results" (F/P/T Advisory Committee on Population Health, 1999a, p. 8). According to The F/P/T

Advisory Committee on Population Health (1999a), the distinguishing feature of intersectoral action is the explicit intention of participants from diverse sectors, and different levels and parts of a particular sector, to address a common purpose.

9.2.3. Introducing the HSMM Teams

Each team was "attached' to a HSMM neighbourhood-based site. One HSMM team operated bi-weekly drop-in sessions at the Evergreen Community Centre. The other HSMM team held bi-weekly drop-in sessions at the Willow Community Centre. Each HSMM team included a minimum of a peer outreach worker, a dietitian, and a public health nurse. HSMM team staffing configurations at the Evergreen Community Centre and the Willow Community Centre varied slightly and they are described below:

- **Evergreen Community Centre HSMM team**--included one dietitian* (Beth), one peer outreach worker* (Alice), one public health nurse (Sharon), formerly employed by the City of Winnipeg Community Services Department, and presently working for the Winnipeg Community & Long Term Care Authority (WCA); and a community nurse/health educator (Jane) employed by The Family Health Centre. A University of Manitoba Foods & Nutrition student volunteer assisted the team with food preparation on a regular basis. The role of the student volunteer in HSMM is addressed in detail in Chapter 10.
- **Willow Community Centre HSMM team**--included one dietitian (Judy), employed by The Wellness Centre; one peer outreach worker* (Diane); two public health nurses (Brenda and Anna) formerly employed by the City of Winnipeg Community Services Department and presently working for the WCA; and a Foods & Nutrition student volunteer. The two public health nurses shared one position on the HSMM team and they were interviewed separately.

Other individuals loosely "attached" to the HSMM sites included child-care volunteers. Although they fulfilled an important role, these volunteers were not included in the research design, because they did not participate in the drop-in sessions and they were not normally included in team planning and de-briefing sessions. (Note: * indicates that the team member is HSMM Core Staff.)

9.3. Breaking New Ground

Alison, a nursing manager with lead responsibility for The City Of Winnipeg Public Health Nurses working on HSMM teams, suggested that the nurses' involvement in the program "broke new ground "in two fundamental ways. First, prior to the initiation of HSMM nurses, worked primarily in the area of postnatal care. With the introduction of HSMM, their role in providing community-based prenatal services became more firmly established. Second, nursing involvement on the HSMM team represented a new model of integrated service delivery at the community level. Alison described how HSMM's concept of teamwork contrasted with the public health nurses' experiences in another program administered by Planned Parenthood Manitoba. The quotation below illustrates the "re-socialization" of nurses' roles (Stewart, 1990a) necessitated by the program's emphasis on interdisciplinary collaboration and the provision of peer outreach services:

> *I think HSMM was different--it is different. With Planned Parenthood it was more of a referral kind of system, where Healthy Start was much more a team working together every second week in delivering a program . . . not just a referral process. HSMM is public health nurses making home visits to the participants, relaying that information to the peer outreach worker, connecting with the peer outreach worker, trying to work together with those families. Whereas, I think with Planned Parenthood a little bit of that happened, but it was very much on an individual basis--it wasn't on a group basis, and it wasn't based on a team-model.*

Alison stated that she realized retrospectively that the nurses were not adequately oriented to their new and challenging roles in the HSMM program. She stated that, *"being one of the managers, I made the huge assumption that the nurses were ready, because we had talked about it* [the nurses' role in the program]." She described why some of the nurses were initially threatened by HSMM:

> *It was a little threatening, I would say. And also for the peer outreach workers, there was learning there as well as to how far their role extended and the boundary issues. I think that a lot of trust had to be developed between the public health nurses and the peer outreach workers. The concern for the nurses was the safety and well-being of the moms and not always knowing what the peer*

> *outreach worker was capable of doing, or not capable of doing. And I think the peer outreach worker also had similar concerns . . . does the nurse* *really* *understand what this participant is going through? And, learning what kind of relationships the public health nurses were able to develop with participant women. So, there was a little bit of growth that needed to happen.*

Alison elaborated on how the configuration of the HSMM team was new to the public health nurses. She compared HSMM's concept of teamwork to the model that the nurses were familiar with in the public school setting:

> *They may have known the players; they knew the nutritionist in the field, but they didn't work in the same way. It was more of a referral process, it's not a team. So, I think that that was the difference. If you had case conferences regarding families in the school, the decision would be who was going to do what--on their own, kind of thing. But when you're trying to develop a plan, a team plan, it's very different, and I think that was a learning process.*

Anna described how the nurses' involvement in HSMM strengthened their role in prenatal service delivery at the community level. She commented on the way in which prenatal involvement with a HSMM participant altered the nature of the nurse's postnatal relationship with the same woman: *"Rarely, very rarely, do we have prenatal referrals. Normally we will see them* [the mothers] *at the time of the birth of the baby."*

The interviewer asked Anna to describe how doing a postpartum visit on a HSMM participant compared to a home visit on a woman who had not been involved in the program. She explained the difference: *"Oh, it's totally different. Because they know you. You have talked, they have asked you questions, they have come to the site and you have eaten there together. So, it's different."*

Sharon reflected on the nurses' past efforts to operate informal prenatal drop-ins in their communities. She suggested why previous prenatal programming targeting the HSMM population had met with limited success and acknowledged the importance of HSMM's supports:

> *In the past we tried to initiate these kinds of groups in our communities ourselves, whether they were parenting groups or a prenatal group. But without the supports that come from HSMM it was difficult to keep going or to 'entice' people. I hate to use the word 'entice,' but part of it is that. In the past when we attempted to do it ourselves, we found that it is a lot of work for one individual to actually coordinate, set up, and provide a program. So, it's nice to be working in a team where the women are made aware of HSMM through various means. It's not just*

> *clients specifically from our neighbourhood--it's a broader experience. It's nice to have a spot, a facility, like we have to come to. It's also good to have something tangible to give the moms, in the way of resources. And, of course, the food is always a real benefit--the milk and the juice components. That, I think, is really, really important for the moms. Also, the resources, . . . Healthy Start has really good resources: the videos, prenatal manuals, and now some postnatal sorts of information and booklets.*

Sarah, the HSMM manager, concurred with Sharon that the program offered the public health nurses tangible, practical resources that were previously unavailable due to budget restraints:

> *The thing is, the nurses are so busy, and hungry for anything new. They're happy. So I think they feel we have great resources, and I think we do, and I think that's been an extra boost, something extra we've been able to give back to them that fills a gap in their system.*

Sharon' and Sarah's comments referred to the community organization process of organizing people around problems and issues that are larger than group members' own immediate concerns. Sharon suggested that the public health nurses had neither the time nor the resources to invest in the community-building process that ultimately gave birth to HSMM. She emphasized that the nurses had benefited greatly from the tangible supports offered by the program and the opportunity to expand prenatal programming in new and innovative ways.

Nan, an ex-HSMM dietitian, observed the public health nurses operating a postpartum drop-in session at the Evergreen Green Community Centre site. She partially explained the sharp contrast in participation rates between the nursing-run drop-in session and the HSMM drop-in session, both operating from the same site on alternate weeks. Nan's comments underscored the value of the community organizing process in enhancing what any one agency and/or organization could accomplish alone:

> *In one of our sites* [Evergreen Community Centre] *we had almost rapid-fire community response and it became one of our busiest areas. In that same building, on alternate weeks, the public health nurses were running a Well-Baby Clinic. And the participation rate was really, really low. They were wonderful nurses, they worked on our HSMM team. What was the difference? Their resources didn't allow for them to have food; that could be one. Their resources didn't allow for the peer outreach component which was really important--the knocking on doors, breaking down the barriers, helping to get the moms in the doors of the Centre. The nurses would bemoan the fact where they were working*

> *alone as nurses in the community, they couldn't get the same response that HSMM could, in exactly the same geographical location.*

Sharon discussed the public health nurses' long-standing involvement in teaching prenatal classes in the Winnipeg inner-city community. She contrasted the "traditional" prenatal class to HSMM's approach with prenatal programming:

> *I think that the traditional classes are more structured in that people expect a certain 'progression of information' to happen. People come with expectations of getting information, doing breathing relaxation, that sort of thing. And when we have tried to do that at Healthy Start, even the breathing relaxation, the moms seem to shy away from that. Some of them want to actually experience doing that for preparation for birth, but the majority of them don't. So, I guess in a way the clients attending the traditional classes are demanding a different type of information. At Healthy Start we tell the moms, 'This is not a prenatal class, so if you want structured information, than you need to register elsewhere.' Some moms will say, 'How come we're not doing this, this, and this?' And we'll say, 'If you're interested, there are other classes where you can go for six to eight weeks and get all that information.' So, I think that the traditional classes being more structured, where they can bring a partner, on a regular basis for a limited period of time, that's not what Healthy Start is.*

Sharon was asked if "traditional" prenatal classes were available free-of-charge to women living in the inner-city community adjacent to the Evergreen Community Centre site. Her answer suggested that cost would be a barrier to moms' participation in "traditional" prenatal classes: *"So far, those at the Family Community Centre in this area are free, but there aren't very many free ones anymore. Actually, the classes that Public Health offers in the evening are probably the only free ones."*

Sharon expanded on the lack of a formal lesson plan or *"progression of information"* at HSMM's drop-in sessions. She reiterated that the team's programming plans were very flexible, often changing at the *"drop of a hat"* in response to the identified needs of participant women:

> *Sometimes we've had something planned where we've had to change on- site because someone else* [a participant woman] *has come up with a major concern. I know that in the last four weeks we had planned to do breast feeding because it was National Breast Feeding Week. The concern that came up two weeks before was, 'We need to know more about circumcision,' because there were a few mothers who were going to be delivering, and they wanted the information. So, we asked all of the moms, 'Is that what we should do next time?' even though we had plans to do National Breast Feeding Week things. They said 'no'" they'd rather*

> *do the breast feeding, so we changed. We try to meet the needs of the moms, if they will tell us what their needs are.*

Paula, a HSMM peer outreach worker, discussed the evolution of HSMM's "Kitchen Table" Approach to delivering information at the drop-in sessions and how the teams worked together to develop strategies that would meet the needs of participants. The "Kitchen Table" Approach, a major theme emerging from the research, is described in detail in Chapter 4. Paula used the following example to describe how HSMM's approach represented a steep learning curve for team members. Her comments emphasized the need to "re-socialize or re-professionalize" nursing/dietetics staff to assist them in developing new roles compatible with the principles of primary health care (Stewart, 1990a, p. 10). Paula explained,

> *For example, maybe the team members were coming in with more paper and kind of a 'class' would happen where, 'Okay, here's all the information, blah, blah,' and passing out paper to each woman. Coming in and teaching more of a prenatal class or delivering nutrition in a different way. With time, and with everyone working together to say, 'Look, we need to deliver this information differently . . . this is how' and really sticking to the philosophy of Healthy Start and showing through example how we wanted this information to be delivered. And it takes time to develop resources to do that. How can you talk about nutrition and not in a dry way? Are there a lot of resources out there? So, it's working together with other dietitians and with team members to try and develop resources--developing resources to deliver the information to the women.*

Health professionals on the HSMM teams spoke frankly of the personal challenges that they experienced in transitioning from "formal" methods of teaching prenatal classes to HSMM's "informal" approach. Brenda insinuated that nursing management had failed to appreciate the training and orientation that was necessary for the nurses to function effectively in these new roles. She confirmed the comments of Alison (a nursing manager) that the nurses were not adequately prepared for their roles on the HSMM teams:

> *I think at the beginning I was looking at a more formal way of teaching and we were kind of told, 'No, it should be informal.' That was really a big adjustment for us* [public health nurses] *mentally. Because we'd never done it. We just haven't done it. It's just like you're doing formal classes in a classroom setting, and then all of a sudden you're asked to sort of walk among these people and share your information informally. How do you make it real to someone? How do you make it real so that they would understand on an informal basis? That's like me telling*

> *you to go out among the people and start talking about nutrition on an informal basis when you've been in a classroom setting. What pictures do you show them? And are you getting it across? And do they really want to know this? All sorts of things, and not receiving any support for that, but just told that you'd better do it.*

Brenda was asked to clarify what *"not receiving any support"* meant. She replied:

> *Someone* [nursing management] *not really understanding that it was a big change for us.*
> Interviewer: *So, how did you learn?*
> Brenda: *Just by gosh and by golly. It was just by trial and error.*

Brenda's comments underscore the significance of organizational processes in creating a culture supportive of new and emerging roles for professional staff. At the program implementation stage, the "buy-in" from upper management in stakeholder organizations was necessary to support the innovation, particularly the training/orientation of staff (McLeroy et al., 1988). Consistency between HSMM, and the partner organizations' missions and goals, was essential for the successful institutionalization of the program in the Winnipeg community.

Alice, a peer outreach worker assigned to the Evergreen Community Centre site, contemplated the early days of HSMM team formation and the importance of individual team members fully appreciating each other's role. She described how a practicum experience with the Public Health Nursing Department, acquired through formal peer outreach training, proved to be invaluable in increasing her understanding of the nurses' role in the community:

> *I did my practicum for three months with the public health nurses, so I think I had one up on everybody else because I understood how they worked; I worked with them very closely. I had a different perception in my mind of what a public health nurse was, and so working with them, I got to really see what they do and what their job consists of. So, I think that helped me a lot in coming together as a team because I understood them and they kind of understood me. At first, I really didn't know. I had taken a course, but I just didn't really know exactly what I should do, or how I should do it. I had never worked with dietitians before. I worked with one when I was pregnant but I never really knew what a dietitian did. I'm sure the nurses did, but they probably saw dietitians more in a medical setting too instead of in the community. So, I think the first little while was just understanding each other's roles and what we can do at the drop-ins and how we can help the moms.*

Alice explained how she saw the role of the public health nurses evolve through their active participation in HSMM. She commented that participant women were now seeing the nurses through different lenses. In the following quotation, Alice observed a shift in nursing roles from expert service provider to facilitator and partner as described by Drevdahl (1995):

> *I think the moms are seeing the nurses differently now. I think a lot of them didn't know the role of the public health nurse. You knew she might come out to see you after you had your baby, but you didn't know that she was such a good resource, that she could link you up to all kinds of different things. The moms have questions that only the nurse can kind of talk with them about . . . there's lots of medical stuff and we definitely couldn't do without the nurse. We try to make it the moms' program, and I always tell moms when they come to the drop-in, 'It's not a class. We try to make it whatever you girls want to talk about, that's what we'll talk about.' And, I would say most of the time they do want to talk about labor and delivery, so we almost have to break up so the dietitian gets her piece and the nurse gets her piece, because there's usually questions from both sides.*

Sharon, a public health nurse, spoke of the critical importance of understanding each other's roles and responsibilities. She admitted that initially it was a struggle, especially in the nutrition area. As several interviewees referred to tension in this area, it is addressed further in the following section on "Growing Pains." Sharon stated that

> *I think in the past we had to struggle a bit about where our focus and our strengths lie. Nutrition had been a part of our* [nursing] *responsibility, also part of our teaching, prior to HSMM. Nutrition can span into lifestyle things that nursing would do, but that nutritionists are versed in also. So, at our site I think we've come to this happy medium where we look to each other and say, 'Can you add anything?' where one person isn't going ahead and doing all the educating.*

The role overlap in the nutrition area can be partly attributed to the emerging presence of the community dietitian in HSMM, discussed in Chapter 10. While many of the nurses were familiar with the hospital-based role of the dietitian, the community role was new and undefined. According to Lister (1983), role ambiguity occurred especially in those areas of community-based practice that were outside the more traditional role of a particular discipline.

Sharon went on to explain that as HSMM team members became increasingly comfortable with each other's role, the functioning of the team improved. She implied that the team continuously worked at clarifying roles and responsibilities, especially when new members came "on board":

> *I think that the way we work has improved on our site over time, as we continue to understand each other's roles. That really needed some time--to experiment and to understand each other's role.*
> Interviewer: *It sounds as if it's something that you continue to work at?*
> Sharon: *Right, yes, I think always. It depends on the person that's there too. Some people may have a broader understanding . . . . If you've been a dietitian in the hospital you may not know what public health does. Depending on who the players are, that strengthening has to be continuous and ongoing.*

Sharon discussed how her involvement with the HSMM team had resulted in increased communication with public health nurses who were not directly involved with the HSMM program. She explained that the HSMM drop-in sessions often attracted women who lived outside the boundaries of her nursing district. When a participant living outside the community required follow-up assistance, it was necessary for Sharon to contact the public health nurse working in the woman's geographical area. In the second quotation, Sharon pointed out that the HSMM drop-ins were increasing other service providers' access to participant women and their families:

> *It's difficult to access some of those parents in the community. They don't have phones, they're not there when you drop in, there's a lot of apartment blocks where you don't have access to them. In that way, HSMM is good for us because we have access to moms on-site. Sometimes the public health nurse is having difficulty accessing the moms, and then we'll see them at the drop-in and refer them back to the neighbourhood nurse. Sometimes the nurses will say to me, 'Oh, I'm so glad you saw them* [mom and baby] *at the drop-in. Did you weigh the baby at least to see how they are doing?'*

In response to a question asking Sharon how often she contacted other public health nurses to discuss HSMM participants living in their respective nursing districts, she replied:

> *Actually, I would say a fair bit. There's usually, say, two moms per week out of the fifteen or twenty, that have ongoing concerns. Fairly in-depth kinds of things like weight gain . . . where nursing follow-up is necessary. I had one last week where the mom didn't have a phone, and the public health nurse had tried to drop in a number of times. Child and Family* [Services] *was also involved. Child and Family* [Services] *was having trouble accessing the mom, the public health nurse was having trouble accessing the mom, and yet this young couple comes to*

> *Healthy Start regularly. They have come prenatally, they have come postnatally, and they're excited about this baby.*

Sharon's response implies that HSMM had increased the access of other service providers, in this example Child and Family Services workers, to clients who sometimes "fell through the cracks."

9.4. Growing Pains

An original member of the HSMM team (Judy) acknowledged that initially there was an uneven commitment to the program among team members:

> *Some team members came because they were told to as part of their being in the community, . . . and so they were told by their supervisors, people higher up in management, that this is a program that they had to be involved with. So, we didn't all come in with the same motivation or the same desire for the program, and yet we all saw the need for it and wanted it to be successful. At the very start, we weren't all certain what it was that we wanted to do, or how we would get women there, or whether we'd get their continued attendance. And so it terrified us, I think, at the very beginning and really had us challenged.*

Judy recalled a team decision to introduce crafts as an "ice-breaker" activity at the drop-in sessions. She suggested that successful team decisions increased the confidence of members to try new and innovative activities with participant women. Judy emphasized the importance of regular team meetings in building and strengthening relationships between HSMM team members:

> *At the very beginning we used crafts. We found that if we could get people doing a craft, and they were using their hands, they would be listening as we were chatting . . . . We know that people in this area don't really like groups; they're not very comfortable with them. So, we wanted to somehow have a group without having a group. We spent a lot of time talking about how to do that--how we could get people involved in doing different things. And, as we did that, the team really started to grow. We had to grow close in order to do it. We wanted to meet as a team because we all individually felt so challenged. We just had wonderful team meetings, and we had such a sense of humor in our groups. We were able to share things.*

As she reflected on the team's "growing pains" Judy described a situation that had been problematic:

> *We had our challenges because we had a lot of issues that had to be dealt with, where one of us would think one way and another would think a completely different way. So, just as an example, in some of the kits* [Healthy Start's Meal Bags] *they used canned vegetables, and we still have ongoing discussions as to whether we should be using canned vegetables in our kits because of the salt--they're not as healthy as frozen vegetables--or whether we should just say to women, 'Buy some frozen vegetables to put into here.' So, we have an ongoing discussion about this at our meetings.*

In this example, the nurse, dietitian and peer outreach worker tried to reach consensus on whether the nutritionally inferior canned vegetables should be replaced by higher-cost frozen vegetables in HSMM Meal Bags and in recipe information provided to participant women. Judy's answer suggested that the team had not yet reached full agreement on the issue.

Nan, a community dietitian, recalled challenges in negotiating a comfortable and appropriate role for the public health nurses at the drop-in sessions. She discussed the nurses' initial hesitation to commit too much time to the program, given their busy work loads:

> *There were frustrations as well. Especially, the public health nurses who contributed . . . . They'd already been out in the community and they knew a lot about how to do that. We had a wonderful commitment from nursing, and not one of us would have wanted to go in there* [a HSMM drop-in] *without a nurse. I remember when HSMM was first starting many nurses said, 'Are you going to need a nurse at the drop-in all the time?' Within a very short time nurses were vying to be there and nurses themselves were identifying the need to be there. I remember having to go into a site and we couldn't get a nurse to come that day. We had set up a telephone system where we could reach one in case something happened. That day a woman came in with breakthrough bleeding and it was such a relief to have nursing backup. I never wanted to go in there* [a drop-in session] *without the nursing component.*

Nan described her experience of the interpersonal-team issues and goal conflict, arising from value differences among team members. The apparent sources of role conflict included role ambiguity, overlapping competencies and responsibilities, and preconceptions that professionals sometimes bring to their positions. She discussed the difficulties that arise when members of one professional group appear to act as if they "own" the client, or the entire range of health issues:

> *The nurses were interesting to work with. They have such a long history in their community and they know their neighbourhoods so well. I don't think the nurses intend to do this but, on occasion, some can come across with an attitude of 'ownership' of participant women. They communicate a sense of ownership like 'my moms,' or whatever. So, I think that the peer outreach workers moving into the community were a threat to some nurses and we had to work hard to establish the credibility of that person* [the peer outreach worker] *and the idea that the role that they could play was not instead of a nurse--not a cheaper way to get a 'nurse' out in the community--but that it was an enhancement to the nurse's role.*
>
> *Just because a nurse is 'in there' doesn't mean that Mom will act on the nurse's advice or that she will chose to believe the nurse. Some nurses found the idea of a peer outreach worker going into homes to speak directly with a mom threatening. One nurse in particular really had a hard time with this, and one day she challenged it. My suggestion to her was: 'If that's your fear, you're better off supporting the peer outreach worker so that she feels comfortable with you--not scared of you--not scared to tell you what the mom asked. This way, the outreach worker can vet her response to the mom by you first. If the outreach worker feels that she's out of her depth, you want her to feel comfortable admitting that--you want her to admit her limitations and come to you for support and clarification.'*
>
> *So, it's better to perceive the outreach worker as a colleague and as an extension of the nursing role and to work with her. They* [peer outreach workers] *will reach moms that shut down automatically with us. That is, moms will often choose to speak to a peer rather than a professional. Mom has, and should have, ultimate control over who she speaks to. The health professional cannot choose the source of information that mom finds most credible, or the service provider that Mom finds most approachable.*

In the above series of quotations, Nan emphasized that HSMM was based on professional collaboration and partnership with participant women, social networks, and peer staff. In fact, the linkages between HSMM team members and participant women closely matched the interactions reflected in Figure 2.5: Nursing Education Conceptual Model Based On Social Support (Stewart, 1990a). Reflecting on the model, I appreciated that within the context of HSMM, other community-based practitioners needed to be included in the "box" entitled Nursing.

Nan described why she felt that the public health nurse members of the HSMM team experienced more role conflict than did other members of the team. Nan, a dietitian, had obviously given this issue a great deal of thought and she chose her words carefully:

> *Dietitians are often guilty of perceiving themselves as exclusive experts in discreet areas of health care. I think that nursing training, because it includes a bit of everything, often creates a breed of health professionals who may regard themselves as being experts in all aspects of health care. Some* [nurses] *see*

> *themselves as 'equivalent to' or a ' replacement for' a social worker, psychologist, dietitian, etc. rather than seeing themselves as knowing 'a bit about' each of those fields. There are many wonderful exceptions, but, generally speaking, it seems a struggle for the nursing profession to acknowledge their limitations and the limits of their knowledge in other disciplines. For similar reasons, I'm often impatient with my own profession, but lately I see encouraging evidence that dietitians are capable of acknowledging the limitations of their training, the constructs they work under, and the assumptions that they make.*

Alice, a peer outreach worker, spoke at length about her efforts to reinforce the "nutrition" component of HSMM, and the challenges that it presented in the early days of programming: *"I think getting that piece across that Healthy Start wasn't just a prenatal program--to keep reminding people that it's a prenatal* *nutrition* *program, not only a prenatal program."* In response to a question asking Alice to explain why people would forget that HSMM was a prenatal nutrition program, she replied:

> *I guess a lot of the questions that were coming through were medical. Moms sort of seeing the drop-n as a prenatal kind of thing--forgetting that nutrition piece. So, there'd be questions about labor and delivery, where the nurse would automatically take over and say, 'Okay ,this mom that wants to talk about labor and delivery, so I'll do labor and delivery next week,' and sort of forgetting the nutrition piece because there weren't a lot of questions about nutrition, Because even the moms probably weren't used to working in a group that had a dietitian.*

Alice spoke proudly of HSMM's emphasis on nutrition and how the participant women responded so positively to the community dietitian on the HSMM team:

> *I would say that it took a long time for the dietitian to get full time at the drop-in, instead of the nurse getting a full hour kind of thing. I think initially, it seemed like the dietitian was always in the kitchen preparing the meal.*
>
> *I always call it a prenatal nutrition program, because to me that's what it is, instead of just calling it Healthy Start. When I describe it to moms, I tell them, 'There's a dietitian there that you can come and see,' and the moms love that--knowing that they can weigh themselves and meet with the dietitian. And I have moms that just want to come and talk to a dietitian because she hasn't been eating. I think that's sort of evolved . . . the nurses realize that there's so much about nutrition that they didn't even know, maybe just skimmed over in school, and that there's lots of questions out there.*
>
> *I guess I've seen a drive from the nurses to take a back seat now and really* *push* *nutrition, because like I said, at first they saw HSMM sort of like a prenatal class and now they're always saying, 'Those moms have to be in the kitchen.'*

Jane, a community health educator/nurse employed by the Family Health Centre, described the struggles to secure an appropriate place for the dietitian on the HSMM team. Alice's earlier comments, combined with Jane's above, support Nan's conclusion that it was difficult for some nurses to relinquish the expert role in the nutrition area in favor of the highly collaborative partner role demanded by HSMM:

> *I know that were some areas of expertise to be sorted out at various times in HSMM, and certainly reiterating that the 'nutrition piece' is done by the dietitian--that the dietitian is the only person allowed to prescribe prenatal vitamins professionally, and that the nutrition profile* [assessment] *is done by the dietitian. The other staff on-site would certainly take an active role in doing the prenatal profile and doing the postpartum piece as well, but that the nutrition would only be done by the dietitian so that there was that continuity and there was that recognition that this was their professional area.*

In response to a question asking if the roles and responsibilities of the dietitian were formally "spelled out" in a HSMM policy, Jane replied:

> *I don't believe it is. It came out of a time where there was some concern--different people doing the nutrition profile, which really wasn't an area where they had expertise. And so then to take it back and say, 'No, this is the dietitian's piece; this is their role; they have the most accurate information' And so in terms of consistency, it should be one person dealing with the nutritional concerns, and prescribing the prenatal vitamins, and doing the follow-up around the nutrition piece.*

The principle of "respecting what participant women know" was of prime importance to HSMM's core staff. Labonte and Robertson (1996) supported the concept of "starting where the people are" by stating that "if we fail to start with what is close to people's hearts by imposing our health concerns over theirs, we risk disabling effects" (p. 441). At a community level, these negative effects include being irrelevant, increasing feelings of powerlessness, adding to the stress in individuals' lives, and focusing on individual-level changes rather than local activism necessary for changes in the broader socio-economic environment. Paula recalled how the HSMM core staff members worked diligently to ensure that programming consistently reflected the program's philosophy and values:

> *We* [HSMM core staff] *really had to stick strong to our beliefs, and sometimes we still do. We have to remind ourselves time and again, 'Look, that was pretty dry how I just did that. What can I do to make this different?' Many ideas will come*

> *out at our team planning meetings when we have time to reflect. Sometimes, the core staff at Healthy Start just know--we can just look at each other to say, 'Okay, that did not work,' and we know, . . . we know what we want to do; we know what needs to be done, and how it needs to be done.*

Paula spoke of the challenges in working with new team members and the importance of orienting them to their roles and responsibilities. She implied that most individuals responded positively to the opportunity to work with HSMM and they appreciated the opportunity to enhance their knowledge and skills:

> *When new team members come in, it's more like, 'You may have never have seen this* [way of working] *before, but look what you're going to experience and what you're going to now bring to whatever job you go to afterwards. You're going to have this experience in how things can be done.' I have not worked with anyone who slams Healthy Start, or thinks we do things in a poor way at all.*
>
> *For certain people, let's say people who have worked in a clinical setting their whole career, it is difficult. Our drop-ins for some people can be just mind boggling, because we go with the flow. We could have something totally planned, 'Okay, we want to do this activity today.' If something else comes up in the group we drop everything and it can totally shift to another thing. For some people, who have done things differently, it can be a difficult thing. But, again, that's where team work comes up again. It's not just one person that's there. You're supporting each other all of the time. I believe so strongly in the whole team approach, because that's what makes Healthy Start what it is . . . . I'm there, the dietitian is there; the nurse is there; the nurse from the clinic is there, because we have clinics involved now, the community clinics coming in, which is excellent too.*

In the above quotation, Paula introduced the concept of the *"whole team approach."* Her understanding of the approach was somewhat consistent with the holistic "total-systems" concept that explicates the interconnections between professionals' traditional areas of responsibilities as a means of reducing the conceptual boundaries that exist between various disciplines (Mariano, 1988, p. 285).

Several interviewees provided examples of "turf issues" that developed when one professional on the team provided information to a HSMM participant that conflicted with the professional opinion of another team member. Judy discussed her experience with "turf issues" and provided a "nutrition" example that illustrated how such issues were handled by the HSMM team:

> *We've had some turf issues; I can't say that there's not been, and we've tried to resolve them the best we can and tried to do it without treading on toes. We had one example, and it was over raw eggs, where one of the team members raised the issue of eating raw eggs--that that was okay to do during pregnancy. So, we dealt with it by just raising the question. Right in the middle of the drop-in, I said, 'Is this something that should be done during pregnancy? Is it safe to eat raw eggs?' We were lucky that we had a visitor that day, the Nutrition Consultant with Manitoba Health. She wasn't there at the time that the question was raised, but when she came in we raised it again for her to give some advice, and she did. So, we've tried to deal with things that way, not by confrontation, but more, I don't know what you'd call that, by continued discussion, and I think that's been very helpful. The odd time there has been confrontation on our team. It's not been healthy--it's been very hurtful--not productive.*

Jane discussed "growing pains" related to partner agencies and organizations having policies or protocols that, on occasion, clashed with HSMM's approach to working with participant women. She called on HSMM to develop specific policies and procedures to inform and guide the practice of team members:

> *I think that speaks to the need to have a really clear policy because when you're bringing people together from different places, different agencies, to have a process clearly defined, that everyone understands and agrees to it . . . . I think that if we're going to be a team, then decisions need to be made as a team. Where there's concerns of safety, or child welfare, that still is a team decision, but that's very clearly defined. If you have concerns about someone's safety or the safety of their child, there still is a very clear line of authority on how that's dealt with--but it's still dealt with as a team. It's not going back to the Family Health Centre and saying, 'Gee, I think this child is at-risk. I'm going to phone CFS* [Child and Family Services]. *' That undermines the credibility of the program and the credibility of the team. I think that that is something that has to be clearly defined right from the start--that when there are concerns, then it's dealt with as a team, that the woman is involved in sharing that concern, so that we're not working at cross purposes. That we're not undermining the trust that has been developed for that woman with that program, because it is often times the only support that she has. You can't have one philosophy here and another there, there has to be consistency. When you're at this site, we're all part of the Healthy Start team. This is our protocol; this is our policy; this is how we deal with issues, and that remains constant. So regardless of the people coming or going, you have this constant policy.*

Jane's comments refer to the important organizational processes that affect the degree of program implementation, and to the depth and breadth of institutionalization. McLeroy et al. (1988) stated that during the institutionalization phase "the consistency between the innovation and the [partner] organization's mission and goals, and the extent to which there is an appropriate niche for innovation within the [partner] organization are all related to successful institutionalization" (p. 362). Jane's comments also draw attention to formal (and informal) rules and regulations for operation at the organizational level that affect program sustainability.

When asked about her experience with "turf issues," Beth suggested that role conflict and/or "turf issues" were best addressed by talking about them openly at a team planning meeting or a de-briefing session held after the drop-in was over:

> *We're all women and we all like to talk. I don't know what it is, but I think what you do is, you all come out, say for a debrief, and you're all kind of wound up about a certain thing. You have one perspective, and someone else has another perspective on a certain topic, or about a case, or a situation with a specific mom. There is some tension there, but I think underlying all of that, if we all keep in mind that we're here for the best of the woman. What's the best thing that the woman would want? I think including her in that, by maybe having a peer outreach worker talk to her and find out, what does she want to do about this? Or, these are things that we have concerns about; does she* [the mom] *have those same concerns?*

Jane agreed with Beth and stated that to effectively resolve turf issues it was necessary to share information openly, thoughtfully examine and consider differences, and provide frank and constructive feedback. In the communication process, team members needed to employ negotiation, facilitation, and team- building strategies rather than engaging in power struggles, tyranny, or control. She described her experience as a HSMM team member further:

> *If one of us overhears the other person giving information that we feel isn't complete, or maybe misleading, how do we address that? It's bringing to the table some of our feelings, and hopefully in a respectful and non-threatening way, and generally that's been the experience.*

Brenda alluded to one issue that had surfaced in the early days of program implementation and, in her mind, had yet to be resolved:

> *There's an attitude that I don't really agree with. . . . That is the attitude that in order not to offend anybody, to make anybody feel bad about their actions or lifestyle or whatever. . . . In order for the moms not to feel badly, we have to really, really, be careful and walk on eggshells, and I do not agree with that. An issue would be, let's say, maybe alcohol during pregnancy. That would be an*

> *issue. So, then how would you approach this without making the mom feel guilty? I'm not saying that one should make the mother feel guilty. Under no circumstances would I say: 'We have to really make her feel guilty in order for her to stop what she's doing' No, that's not it at all. But, I think there is just too much . . . going to the extreme opposite* [position], *and I think that you end up being ineffective, because then you're ignoring it, or not really talking to the mom about it, because you don't want to hurt her feelings. At HSMM, we are expected to be extremely cautious--I feel over cautious. I think that one should be cautious, but not over cautious.*

The above quotation suggests that Brenda disagreed with the "official" HSMM stance on how team members should deal with participant women's lifestyle choices (in this example, the use of alcohol while pregnant). Brenda was an exceptional case--other HSMM team members and key informants did not raise this particular issue during the data-collection process. Nevertheless, it is important to acknowledge that for Brenda, the HSMM "attitude" on this issue was in conflict with her personal position. She appeared frustrated by her inability to deal in her own way with participant women's use of alcohol when pregnant.

There is no question that individual members of our society, like Brenda, believe that it is necessary to take a firm, but sensitive, position on the use of drugs and alcohol while pregnant. It is also not uncommon for citizens to express their opinions, often strongly, on the topic of un-wed mothers. A letter to the Editor in the Globe and Mail (November 26, 1999) expressed a point-of-view common to certain factions of society:

> A Singular Lack Of Planning--Oh, here we go again; another story about government victimization of poor, single mothers. Give me a break! Your story, 'How Canada Broke Its Pledge To Poor Children' (Focus – Nov. 24), would be more aptly titled 'How Irresponsibility Is Driving Children Into Poverty.' Nowhere in your story about Shelley Johnson is there a single mention of a former 'husband.' The reader is told that Ms. Johnson has three children from two different 'relationships.' Well, here's some advice to Ms. Johnson and others like her who so recklessly bring innocent children into this world, condemning them to lives of struggle and uncertainty. How about getting married before you produce your next child? Birth control does exist, you know. And stop expecting the already overburdened taxpayers of this country to continue paying for your foolishness. You get no sympathy from me. (K.E. Matheson, Lower Sackville, NS)

An HSMM document submitted to Health Canada indicated that a primary goal of the program was "to enhance the ability of low income, high-risk pregnant women and new mothers to improve their health and that of their families" (Healthy Start for Mom & Me, 1996, p. 7). The document also stated that the "program would flexibly, and as suitable, enable participant women to decrease or stop cigarette smoking and reduce or stop [their] use of alcohol and drugs" (p. 7). Proposed activities to accomplish the objective included providing informal learning opportunities to assist awareness of nutrition and lifestyle (smoking, drinking, etc.) on the baby's development and health, in either group or home settings.

Additional HSMM program documentation described "the feelings of powerlessness and hopelessness that dominated the day-to-day lives of participant women and their priority struggles for food and shelter" (Healthy Start for Mom & Me, 1996, HSMM, Appendix F). Alcohol, cigarettes, and drugs were considered to be "coping mechanisms" that assisted women in dealing with very stressful circumstances. Attention was drawn to participant women's "fear of being judged negatively by service-providing professionals." The HSMM article suggested that if participant women felt that they were being judged by service providers, they typically withdrew in an effort to increase feelings of personal safety thus preserving their social isolation and their anonymity.

In contrast to Brenda's opinion that HSMM was "soft pedaling" the issue of alcohol and pregnancy, I observed the Evergreen Community Centre HSMM team addressing the topic with participant women in a sensitive, straightforward and culturally appropriate manner. During a planning meeting, team members acknowledged that "National Addictions Awareness Week" was the second week in November. They referred to recent newspaper reports documenting the high rates of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) in Manitoba. An article in the Winnipeg Free Press stated that

> Manitoba has rates of FAS and FAE that are many times higher than recognized rates elsewhere in the world. The recognized rate worldwide for babies born with alcohol impairment is 0.2 percent; in parts of rural and northern Manitoba, the rate is 10 percent, according to provincial statistics. Only 20 children have been diagnosed conclusively with FAS or its related Fetal Alcohol Effects in the entire Winnipeg School Division Number One but there are many more who haven't been diagnosed who suffer the same learning disabilities, according to school officials. (Winnipeg Free Press, 2000b)

The HSMM team decided to approach the Aboriginal Health & Wellness Centre of Winnipeg's FAS/FAE program and request that staff members come to a HSMM drop-in session to talk with participant women. The team had previously participated in an "education presentation" on FAS/FAE, delivered by the Centre, and spoke positively of the program, specifically the use of the Medicine Wheel Philosophy and the integration of both traditional and contemporary techniques. The team was aware that the FAS/FAE Program had recently introduced a "Mentor" initiative, whereby women with FAS presented a first-hand account of their experience, as part of a more comprehensive presentation to community groups.

A young Aboriginal woman (Michele), with FAE, who came to speak to the HSMM participants was the mother of two children (ages 4 and 2). At the time of her presentation, she was 26 weeks pregnant with a third child. Michele told a very powerful and moving story of her experience with FAE, focusing on the challenges that she faced as a child, a teenager, and more recently, as a young mother. She reminded HSMM participants that FAS/FAE could affect anyone, regardless of background or circumstances. Michele reinforced the message that "no amount of alcohol is healthy in pregnancy," and she emphasized that in order to "break the cycle" it was essential for Aboriginal women to embrace the "Seven Sacred Teachings." With the assistance of the FAS/FAE "educator," Michele described, in her words, the Teaching below to the largely Aboriginal HSMM audience:

(1) To cherish Knowledge is to find Wisdom
(2) To know Love is to find Peace
(3) To Honour all of creation is to have Respect
(4) Courage is to face Life with Integrity
(5) Honesty in facing a situation is to be Brave
(6) Humility is to know yourself as a sacred part of creation
(7) Truth is to know all these things. (Nechi Training, Research, & Health Promotion Institute, 1999)

9.5. Supporting Each Other

Interviewees stated that to encourage synergy between dissimilar professionals, and to develop trust between team members, it was necessary to mutually respect and support each others' roles and skills. Findings discussed in this section indicate that

HSMM interactions between health professionals-peer staff; health professionals-participant women; and peer staff-participant women closely matched those illustrated in Figure 2.5, Nursing Education Conceptual Model Based On Social Support, developed by Stewart (1990a). Negotiation among equal partners regarding respective goals, responsibilities, role expectations, and status in interactions between professional staff, participant women, and social networks facilitated effective team functioning. Health professionals jointly assuming partner roles with both peer staff and participant women enhanced the delivery of primary health care services in the community.

Sharon described how HSMM's three peer outreach workers added a vital, unique, and highly valued component to the program:

> *It's hard to imagine not having them* [peer outreach workers] *around. It's just so nice to have another person, or two, just to make parents feel comfortable, and also if you need to, yes, to bring them* [transport the moms to the HSMM site]. *I think that the peer outreach workers often hear a lot about the families' lives that we* [nurses] *might not hear about because the moms feel very comfortable with them.*

She elaborated on the non-threatening role of the peer outreach worker and she stated that, on occasion, the nurse and the outreach worker "teamed up" to conduct home visits together:

> *If we have concerns about not being able to get back to a mom, and it's not a nursing or a medical concern, but we know it's a social concern, it's good to have an outreach worker, that's usually non-threatening, that can go back to the family and even just put in some support time. I know they* [peer outreach workers] *are very busy, and I don't know how much time they actually have to do home visits between drop-in sessions, but that has been good. And I think also just to strengthen the programs we have done home visits together occasionally, so one will strengthen the nursing home visiting program and the other to encourage them to get to sites, saying, 'We will both be there. Come.'*

Paula described her relationship with the nurses and the high degree of trust that had developed between team members. She implied that the relationship between the nurses and the peer outreach workers was based on reciprocal feelings of respect for each other and mutual support:

> *Do I depend on them* [nurses]? *Yes, I do. I definitely see them as my support network in helping the women, because when I have questions, I just automatically pick up the phone. I don't even think twice about it. If I'm on a*

> *home visit and this woman's just asked me a medical question, 'Sorry, I don't have the answer, but I can get it for you really quickly.' And that's why you take cell phones too. If a woman doesn't have a phone, then I can get those answers like that* [snaps her fingers], *or at least get someone into her home. Depend and respect--I have a lot of respect* [for the nurses]. *I think I have excellent relationships with the nurses, particularly in the north end, where a woman could just tell me, 'I'm at this and this address'--I know right away which nurse to call.*

The addition of Community Health Centre Nurses to the HSMM Collaborative Outreach Model (Appendix C) resulted in there being two nursing professionals--a public health nurse and a "clinic nurse"--on some teams. Jane, a "clinic nurse" employed by the Family Health Centre, discussed the nature of her relationship with the other members of the HSMM team. She began by describing how she came "on board," then proceeded to explain how her nursing role and responsibilities had been determined. Jane carefully described how her area of expertise--domestic violence--complemented the knowledge and skills of other members of the team:

> *Initially, I was invited to the site because of my experience in working with women around issues of domestic violence. Because, of my experience in the field, I was invited on-site to perhaps be able to provide women with more information around those issues as they presented in their lives; also to provide Healthy Start staff on-site with some resources and direction in that area--not to do personal counseling on-site. That was never the intent. But there was a feeling that there wasn't always time to connect with women who perhaps had shown some sense that she was wanting to disclose something, but there wasn't always the time. And so they felt to have another person physically on-site would allow all of the team more of an opportunity to spend an extra few minutes with a woman if she was needing it.*
>
> *I will certainly participate in any of the discussions that we're having on the topic of the day, with any information that I have, If it's a health-related issue, I encourage the public health nurse to take the lead because they do primary care in the community. I am a nurse, but my focus is community development and community education, and working more with groups, as opposed to primary care. And because the public health nurses have the opportunity to see women in the home postpartum, it does allow for them to develop a relationship with that woman in a group setting that sometimes decreases any* [negative] *feelings that the woman may have about the nurse coming into her home--that's a barrier for many moms.*

In response to a question asking how the relationships between team members had evolved over time, Beth explained that, after a year or so, team members intuitively knew what to expect from each other. She described the high degree of trust and support that had developed:

> *I think that the relationship changes over time; . . . the more you know someone the more you can trust them. After a year or so, you know who's going to do what at the drop-in, or, you know someone's going to take care of this. You know you can rely on people. If you feel like you're being put up against a wall, or you don't know the answer to something, you know that there's someone there to help you along. It's difficult for that to happen right from the beginning--it's definitely an evolution process. When we're planning our drop-ins, you learn what people are comfortable with, the style that they use when we're talking in a drop-in setting, and I think our de-briefs are a tremendous help with that. They go: 'Oh, I tried to talk about this, but it didn't work today. I didn't really come across the way I wanted to come across.' I think that the planning meetings, the de-briefs, and even our All Sites Meetings help us to connect with each other. And I think that the way our teams are set up is that we give each other allowances. If one of us has a bad day, we're here to help out.*

Several interviewees emphasized the importance of maintaining consistent players on the HSMM team and Jane described the challenges that sometimes resulted from staff turnover. Israel et al. (1994) stated that the "short time-expectations of some health educators, their employers, and community members are inconsistent with the sustained effort that this [community empowerment] approach requires in terms of long-time commitment of financial and personal resources" (p. 157). Jane compared her experience as a member of the HSMM prenatal team to her recent involvement with the HSMM postpartum team:

> *As a prenatal team we've functioned for a fairly long team consistently with Beth, Sharon, and Diane and I. So there is a comfort level in that we do fill in the gaps and there is a flow. I would say that this is unique to that team--it doesn't always exist. It really depends on the dynamics of the group. With the postpartum piece, the public health nurses sometimes will come for a month and then alternate for a month; sometimes they will alternate every two weeks. So, they aren't involved in the planning consistently and you're never quite sure who's coming* [to the drop-in]. *It doesn't allow you that time to develop a relationship with each other in the same way.So, I would say that there isn't the same level of communication. There certainly is value in consistency of team players.*

Brenda spoke of the tolerance and patience that team members afforded each other--especially when dealing with the unexpected. She emphasized the importance of the de-briefing session in assessing how the drop-in had "worked" and in making suggestions for improvement:

> *People* [team members] *are very perceptive--all of us are very perceptive about what works and what doesn't work. No one person would say, 'She did that--it really didn't work' because we're all part of that decision; we're all a part of participating in that activity, so that if it didn't work, it's all of us that were involved. So, we can't really say, 'It was her idea, she did it, and boy, what a mess!' That's not the Healthy Start way.*

Brenda spoke at length about her relationship with the dietitian/nutritionist on the HSMM team and the "shared" leadership style that contributed to the success of the program:

> *My relationship with Judy, the nutritionist, has always been good. I think we work as a team and so that's been very good from the beginning to now. She's always taken a leadership role but it's not something that you take over. Some people take a leadership role and take right over. There's always been a nice balance there. It really is a team, and I think that's the way she works, so it's been very, very positive and, I would say, productive from the beginning.*

Beth, the HSMM dietitian, with supervisory responsibility for the three peer outreach workers, described the support from HSMM management that so significantly contributed to her personal growth and development. She also acknowledged the ongoing support that she experienced from the HSMM Steering Committee:

> *I guess she* [Sarah--HSMM program manager] *has the perspective of the overall picture. Sometimes when you're doing your drop-ins every day, you're coming back to the office, and it's hard to keep that perspective. But Sarah has the ability to do that. And she's very supportive of all of us and what we do, and we're able to kind of air things out with her when there are challenges that come up. And I think if we didn't have that support from management, I don't think that the program would be what it is. I think Sarah has the vision that helps sustain us through some of the difficult times in our drop-ins, and that sort of thing. I think that helps--also having the support of the Steering Committee. Their support, but also their--how would I describe that?--their kind of willingness to share their ideas. They care about HSMM and it really shows. When I've gone to the Steering Committee meetings their interest in the staff, as well as in the moms in the program, really comes out. And having those supports only helps. It helps when you go to drop-ins. You're going in there with the support of everyone else behind you kind of--their ghosts are there with you. And that's always a nice feeling to go to drop-ins like that.*

Judy, a dietitian, discussed the skills that she had acquired from working in partnership with the public health nurses, especially in the area of group facilitation:

> *As I look at the other team members, I know the public health nurses are excellent; they have excellent skills to encompass the whole group all the time. That's a goal of mine--to develop those skills--to become more like them in that way. That's been hard for me to include the individual talk that we need to do, and at the same time not letting go of the whole group that's there. I tend to be very focused when I do an individual interview, but while doing that, to have in a part of your mind where you're going next and the large group dynamics of what's going on around you as well as being focused on that individual. It's a real challenge--it's sort of thinking of two things at the same time.*

Sharon commented on the process of team building and the necessity for professional staff to give up turf to improve the overall functioning of the team:

> *I think that is part of the team-building process where you have to be comfortable with who is an expert in what. Some may be an expert in birth control, where the other might be an expert in breast feeding simply because you deal with it day to day; it's not just text-book knowledge sort of thing. And so over time, I think that's been a bit of a struggle because we don't really cross paths except for every other Tuesday, so it does take a fair bit of time to become comfortable with the other health professionals, because we don't work with them on a daily basis.*

While there had been a limited turnover of members on the Evergreen Community Centre team, the Willow Community Centre team had remained intact dating back to the implementation of the HSMM program in 1997. It was interesting to hear interviewees describe their experience of the team-building process, particularly the "original" members of the Willow Community Centre HSMM team whose recollections spanned a three-year period.

Alice, a peer outreach worker, compared her experience of the team maturation process to the changes that she had observed in HSMM participant women over the course of their involvement in the program. While the experiences of participant women in HSMM are discussed in detail in Chapter 4, Alice's observations are relevant at this point because they capture her experience of the HSMM team developmental process.

Alice perceived that participant women initially felt anxious, uncertain of what was expected, lacked self confidence, and often had serious doubts about whether they would "fit in." Over time, as the moms began to feel comfortable in the HSMM environment, and more trusting of staff and community partners, their confidence increased and they began to share more of themselves with other participants. Alice used this analogy to describe the developmental changes that she experienced as a HSMM team member. She suggested that the team members' developmental process mirrored the changes that she had observed in the HSMM mothers. Alice's observations were insightful and appeared to be consistent with what other team members had experienced.

9.6. Issue of Time

All of the HSMM team members interviewed described ongoing challenges related to the lack of time for appropriate team planning. Anna summarized her concerns:

> *When we discuss Healthy Start in our office, we always say, 'Oh we need so much time, we need so much time.' But it's wonderful, it's wonderful to have the opportunity to connect with women even before they have the baby. The sooner you connect with them, the more chances you have of establishing trust and then being effective if you want to do something. There is not a lot of time for planning, therefore we do what we can. The program is going, but it could be better. I think it could be even better. The basics are there for the program, but if we were to be able to plan.*
>
> *It's a good team. We work well together. Sometimes there were things at the very beginning, growing pains, and even lately . . . . It's because of constraints, time, I think is the main barrier to having the program run smoothly. Otherwise, it's been an excellent team. I think we complement each other, and we trust each other, so we have worked fine; we have worked very well.*

Brenda shared Anna's concerns. She explained that the need for creative and innovative programming at the drop-in sessions required more time and energy than did traditional approaches to teaching:

> *HSMM represents a different way of doing something professionally. It means that you have to be a lot more creative, you really do. And that's also more time consuming, and we don't have it, and that's the downside of it . . . if you don't have the time, it's a real downer, because then you're slapping something together and you hate it.*

Sharon described the challenges in balancing her commitment to HSMM with her other duties as a public health nurse. She explained that her primary and legally mandated responsibility pertained to the control of communicable diseases in the inner-city community that she served. In comparison, her work with HSMM was considered a lower priority:

> *Now it* [HSMM] *is part of our weekly routine but in the beginning it really did impact. We have not received any more staffing because of Healthy Start and there's other programs too that have evolved over the last three years. Our mandate in public health has always been communicable diseases and now since January 1, 1999 we have a new manual of all the new reportable communicable diseases. Hepatitis C is one that in our downtown team there's a few nurses that really, really, have been very busy with follow-up that sort of thing. So it all impacts. Not that it's negative to Healthy Start, but it's just more programs being put on and nothing drops.*

When Sharon was asked whether her involvement in HSMM had significantly changed the way she worked, Sharon replied:

> *In some part it has, yes, because it's a definite time commitment to being on-site. For some teams now as we're getting to know the players better, we can do planning, say, over the phone or we can say, 'You know what? I just can't come to a planning meeting this week. Tell me what you'd like me to do, what you'd like me to bring.' Yes, it* [the time commitment to HSMM] *is significant. Especially if the team takes a lot of time in planning, say, two hours on the alternate weeks. It really does add up, especially if we're down staff in the nursing office, then we really notice it.*

9.7. Importance of Team Planning

Although team members expressed their concerns with respect to the lack of time for appropriate planning, all interviewees stated that effective team functioning depended on regular face-to-face meetings. In addition to team meetings for planning and de-briefing purposes, they agreed that HSMM's All Sites Meetings were both informative and necessary:

> *Anna (public health nurse): I'm really looking forward to the All Sites Meeting that's coming up. I have found them really, really interesting. I always make an effort to be there.*
>
> *Alice (peer outreach worker): I think that All Sites Meetings are very, very important, just getting all of the team members together. I know the nurses and dietitians on the teams look forward to the All Sites Meetings, everybody in the same room together, and just talk about the challenges that you face and knowing that you're not in it alone.*

Nan, a dietitian, recalled the challenges that she experienced in convincing the nurses that the de-briefing session following the bi-weekly drop-ins was an essential team-building strategy. Initially, the public health nurses resisted the idea of the "de-brief" and questioned its purpose:

> *The nurses really are quite committed to contributing to HSMM, where at first they weren't quite sure it was necessary. At the beginning, as we were conceiving how many drop-ins we'd have, how long they'd last, and how we would run them. We knew we were going to need a chance to debrief at the end of the drop-in. We brought this to the attention of the public health nursing manager---that debriefing would be an expectation of the nurse's role. It seemed to be received as an insult: 'Why would the nurses need to do that? They know how to do their work They won't have time to stick around for that. Their time is too important for that.'*
>
> *We kept working it through, site-by-site. The change in attitude toward the debrief, and their* [the nurses] *insistence on including a structured planning time before each drop-in, represented an evolution in the nurses' ability or willingness to collaborate. The de-brief proved to be vital, and the nurses eventually recognized it. They came to see the debriefing as important. It was because they were so busy and so stretched in their communities that in the early days they thought, maybe I can get there for an hour, and then some of the nurses disappeared before you had an opportunity to debrief. But ,over time, the teams evolved and strengthened. Soon, they wouldn't consider leaving us without a nurse--they* [the nurses] *realized that the drop-in required not only the time that the moms were there, but also the time to reflect appropriately after they had gone. I appreciated and recognized that the nurses were really stressed and this took a lot for them to dedicate that kind of time.*

9.8. Lessons Learned

Alison, the public health nursing manager, was asked if she had advice for professional peers contemplating the development of a collaborative, community-based prenatal nutrition program, similar to HSMM. In her response, Alison focused on what she would have done differently in an effort to enlist the nurses' support for the program:

> *I've thought about that a lot. We tried to keep them* [the nurses] *informed; we tried to involve them in all the processes and all the decision-making. We even had sessions where everyone talked about their roles so that people would be clear. When you're working in an integrated service delivery model you have to first start by learning about each other and building trust. So I think in any process you have to go through that stage. What I might have done differently was not start to try to implement the program right away, but give some time for that to happen.*

Sarah, the HSMM program manager, suggested that the highly collaborative model on which HSMM was based represented a "new way of working" for the public health nurses. She described her perception of the impact of the program on nursing practice at the community level:

> *My perception is that this has been a really, really interesting learning curve for the nurses and maybe has challenged some of their previous assumptions about what they do and how they do it. That, in fact, you can come together and work with others in the community, even though previously this was your terrain all by yourself; that somehow something different happens when you put a mix together, and that it can work; so that public health can be a part of it without having to, 'lead it.' I'd be interested to know from a nursing standpoint what impact this has had for them, and my impression is that it's multiple impacts at a variety of levels.*

Sharon, a public health nurse with extensive experience in inner-city communities, described how her involvement in HSMM had influenced her understanding of prenatal health promotion. She suggested that without the infrastructure provided by HSMM, nursing would not have been in a position to offer this type of programming to high-risk women and teens:

> *I've worked ten years here in the core area. I think we always knew that we had to meet the moms where they are--meet their needs, make it comfortable for them, and have it in a place where they feel comfortable, with staff, with other people that they felt comfortable communicating with, and the importance of a nonjudgmental environment. HSMM has given us an opportunity to put some of those things into practice, because of the supports--the food, the outreach workers calling the moms and inviting them to participate, the resources . . . So, it's not so much that there has been a lot of new things with HSMM . . . it is being able to put into practice something new, in a different place, with different supports. Before, we* [nurses] *had to bring food from home. This is the big difference. Now there's somebody that will assist to make it* [food] *and somebody else pays for it. Before, it was either, we would bring the food from home or we would go to the food bank, and you know what you get from the food bank--doughnuts. So, it's kind of counterproductive to do that.*

Sharon also stated that she now appreciated the value and rewards of successful community-based partnerships, as a result of her experience with HSMM. The following quotation is her response to a question asking her to describe "lessons learned":

> *I think also, the whole partnership thing. Having outreach workers, an outreach program that works with the nurses, has been wonderful. That part, linking with and having to work in a new team, interdisciplinary, and coming in with different educational backgrounds, that has been and will continue to be very valuable.*

However, Sharon cautioned that while programs like HSMM can offer "life lines" to high-risk participants, it was important to keep the significance of the services provided to participant women in perspective. She explained that HSMM cannot be "everything to everybody":

> *You know what? It's only every two weeks that we actually meet with these moms, and there could be major changes within that short period of time. I think that Healthy Start has its role and it does well at meeting people's needs within that role, but I'm not sure that it can be everything to everybody.*

Sharon's insightful comments remind the reader that health promotion interventions must go further than the Community Organization "level" of The Empowerment Holoshere (Labonte, 1994). Her comments emphasize the importance of pushing into the next sphere, Coalition Building and Advocacy, in order to move from a bureaucratic process to a social change process. According to Labonte (1994), bureaucratic processes that stop at the level of community organization, are "inherently conservatizing" and often limited by geographic boundaries. Without a strong advocacy component for macro-level environmental changes, practitioners "may again unwittingly privatize by rendering local what are much broader issues" (p. 75).

Anna, a public health nurse, described her learning, including the recognition that it was not realistic to think that all participant women would respond positively to HSMM's approach. She emphasized that she was always acquiring new knowledge and skills, along with other members of the HSMM team:

> *All the nurses will say that we like HSMM. We don't want to see the program end because not only women will lose; we lose, because of the connection, because of sharing the work, because of all of the things that the women are benefiting from . . . . It's rewarding work. I can connect with these women. You can feel the connection with some of them, not with everyone for sure, because some women are very reluctant. But it has given me that opportunity. In a way you are always learning. I have to learn that even if you do use the right tools, the right everything, you're not going to reach everyone, and that's the nature of the work.*

Jane, a community health educator/nurse, spoke at length about what she had gained through her involvement in the program. In the following quotation, Jane compared her work with HSMM to parenting in that the rewards are often more long-term than immediate:

> *First off, it* [HSMM] *is the highlight of my week. I work with women and I work with families. I have always felt a bond in working with women, sharing experiences and the reward of watching them blossom. I have a personal investment in this in that it gives me back as much as I give, which you don't always find in community development work.*
>
> *It's sort of like parenting: The rewards are so far down the road that you often lose sight of the overall picture. Healthy Start is truly the highlight of my week, It has provided me the opportunity to look at our community in a broader perspective . . . and see where some of the gaps in service are, based on these women's experiences . . . There are so many issues that they're dealing with on a daily basis, that I really value the insight that these women have given me into some of the areas where they would like to see more services. So to be able to use Healthy Start as a resource for people who are accessing services at the Family Health Centre, it's just another community resource that I feel comfortable in referring. I like to have a sense of where I'm referring people to, to know that it's going to be safe place so I can say with full confidence, 'Here's this wonderful program, and you can attend at the Evergreen Community Centre; you can go to the Maryland Family Place. If you want to go outside the community, here are some other HSMM sites that are available.'*

Sharon agreed with Jane that HSMM represented a valuable and trusted resource for public health nurses and that they referred clients to the drop-in sessions with full confidence in what the program had to offer:

> *I think the good thing is that we have another resource at our disposal that we're directly involved in, that we can say to parents, 'Come. I'll meet you there. You can weigh your baby, meet other people. There will be something good to eat. You might even meet a neighbour that you don't know, and then you come together or whatever.' Sometimes they don't want to know their neighbours; that hasn't changed. But it's just another resource that we can link them very readily with, and, I think, in a broader way.*

Brenda explained that her personal growth and development related to broadening her teaching repertoire to include both formal and informal methods. She maintained that even within the drop-in environment there was room for formal teaching, on occasion. Brenda explained her position:

> *I really feel that there has to be a bit of both; there has to be a little bit of informal and formal.*
> Interviewer: *Do you think you have found a balance?*
> Brenda: *No. It's an ongoing thing. I find that the formal works better with group, so that there is kind of formal stuff there.*
> Interviewer: *For example, at the drop-in session last week when you talked a little about caesarean births, and you demonstrated how to do the postpartum exercises? That's formal, right?*
> Brenda: *Yes, yes. Even then I'm not going into it in any tremendous detail either. I'm just trying to cover important points, so in a way it's informal because you're not going into too much detail. You only have so much time, so you're looking at twenty minutes to half an hour, maybe even fifteen, depending on how you're holding their attention. After a certain time, they're not going to listen anyways.*

As Brenda continued to discuss the "lessons learned" through her ongoing involvement with HSMM, she suggested that she had gained a new understanding of shared leadership. She provided an example to illustrate her point. The example reflects a highly collaborative mode of interaction versus the co-existing mode associated with traditional nursing practice (Stewart, 1990a):

> *As a nurse I believe that if you don't support one another, say your co-workers, your colleagues, how can you support the moms who come to see you? If you're really busy or overwhelmed or whatever, for whatever reason, that people don't kind of step in and fill the gaps in order for you to do the job. That's part of teamwork. And I think teamwork is not, 'You do this job, I'll do that job.' It's also sort of giving your input and also supporting one another and filling in the gaps when we have to and that's important too. It makes the thing work.*

Sharon discussed the positive impact of the HSMM's new postpartum program (i.e., "Baby Steps") on the prenatal component of HSMM. Sharon stated that she had not appreciated the challenges related to addressing the concerns of both prenatal and postnatal participants at a drop-in session, especially when more than 40 women were in attendance:

> *Before* [the initiation of HSMM's postpartum program] *we really had a struggle between prenatal and postnatal. Now, the 'Baby Steps' program can siphon nearly half of those moms off into a different specific group. Some of these moms have other children at home and they're really not interested in prenatal issues like labor and delivery any more. So, in a way it has made our prenatal group more manageable because it's smaller, It really was difficult when you had almost forty mothers showing up at a drop-in and their concerns were divided between prenatal and postpartum issues.*

Judy described an unanticipated benefit of her involvement in HSMM. She explained that many of the HSMM moms that she encountered at the drop-in, also came to the Inner-city Health Centre for medical care:

> *I've been able to contribute a lot to discussions* [at the Inner-city Health Centre] *on moms that are attending both Healthy Start and the Inner-city Health Centre. I try not to tread on any confidentiality issues, but have been able to contribute to how things are going for the mom.*
>
> Interviewer: *So the learning that comes from your work with Healthy Start is valuable in terms of your work at the Inner-city Health Centre. You're feeding back your observations to staff at the Centre and you're able to help them understand what services might work better with HSMM participant women?*
>
> Judy: *Yes, and to identify issues that otherwise we might not even have gotten at. . . . For example, we had a gal who attended* [the Inner-city Health Centre] *and she had issues* [not disclosed] *related to alcohol. She appeared to be managing very well. To see her, you wouldn't say that she had these issues. Now, someone at the Centre would have asked her about alcohol, but I'm not sure she would have felt open enough to mention it.*

Judy was asked whether the participant woman referred to in the above quotation felt "safe" enough to raise the issue of her ongoing use of alcohol at a HSMM drop-in session: *"Yes, and in fact the peer outreach worker and I met with her and we talked about it at length and referred her on to another service through Aboriginal Health and Wellness."*

9.9. Section 2–Theoretical Constructs

9.9.1. Intersectoral Action for Health

The findings presented in Section 1 indicate that HSMM team members were successful in establishing the horizontal and vertical linkages necessary to promote population health. The horizontal linkages represented partnerships with the following: (a) public sectors including health, social services, education, parks and recreation, library services; (b) voluntary sectors including Dietitians of Canada, quilting organizations that donated draw prizes used at the drop-in sessions, and volunteers who prepared HSMM Meal/Recipe Bags, and, (c) private sectors including retail food outlets involved in the redemption of milk/juice coupons. Vertical linkages in HSMM included health sector partners at the local, provincial, and national levels.

Interviewees acknowledged that it was timely to re-examine the composition of the HSMM Steering Commiittee to ensure that there was broad representation from the various sectors that had participated in the initial stages of program planning and implementation. Key informants also emphasized the importance of involving HSMM participant women in the governance structure, working groups, and volunteer activities associated with program implementation.

The literature on intersectoral action maintains that "building stable teams of people who work well together and have appropriate supports" is critical to success (F/P/T/ Committee on Population Health, 1999a, p. 21). The research findings presented in Section 1 suggest that interdisciplinary teamwork in HSMM was a requisite to establishing horizontal linkages. Advancing population health will not occur without the horizontal linkages. Thus, the importance of seeking shared values, and interests, and alignment of purpose among partners is critical in intersectoral action for health. However, before involving the non-health sectors, intersectoral collaboration has to be successfully demonstrated among the health sub-sectors. According to the Expert F/P/T Committee (1999a):

> Individual departments and organizations tend to have their own culture and language, which can hinder effective communication and joint action. Intersectoral action is not a magic bullet that will automatically overcome these challenges. But it offers a mechanism for action on joint interests that is advantageous for all partners. Success is most likely when an initiative can frame an issue so that players from various sectors can clearly see their stake in it and the potential benefits of participation. (p. 18)

9.10. Summary

This chapter focused on interdisciplinary collaboration within HSMM and the factors that promoted or hindered its functioning. The research examined the dynamics of interdisciplinary teams through the experiences of HSMM program staff, community partners, and key informants. Research findings confirmed that the community organization process gave birth to HSMM's interdisciplinary teams and the Collaborative

Outreach Model (Appendix C) on which the program was based. Host and partner agencies and departments organized around community-identified problems or issues that were larger than group members' own immediate concerns and/or mandates.

Consistent with the ecological model for health promotion (McLeroy et al., 1988), organizational changes were necessary for partner agencies to create a culture supportive of HSMM. Further, following program implementation organizational changes were necessary to fully institutionalize the program in the Winnipeg inner-city community. Research findings supported the conclusion of McLeroy et al. (1988) that it was important for health promotion practitioners to secure upper-level management "buy-in" for the program. At an organizational level, requisites of interdisciplinary collaboration in HSMM included time, demonstrated support, and the orientation/training of team members. These findings were consistent with the position of Mariano (1988) that interdisciplinary team activities will not be successful if the commitments are seen as "add-ons" to team members' discipline-specific or departmental priorities.

A central observation related to the tendency of health professionals to strive for expert knowledge and skill development, largely as a result of their pre-professional training. This emphasis on specialization was sometimes in conflict with the roles and responsibilities necessitated by an integrated model of service delivery. The implementation of HSMM's Collaborative Outreach Model (Appendix C) was premised on staff and community partners approaching issues holistically, using what Mariano (1988) described as "total-systems concepts." The use of this approach resulted in the reduction of conceptual boundaries that existed between disciplines (p. 285).

HSMM's success appeared to rest on the ability of team members to coordinate and integrate specialized knowledge, within a comprehensive health promotion program. The integration of diverse areas of expertise, including nutrition and domestic violence, reduced duplication and strengthened the provision of comprehensive services to participant women. The successful integration of roles and responsibilities depended on professionals having a thorough knowledge of their own discipline in order to see how that discipline contributed to the whole. HSMM staff and community partners who felt secure, confident, and competent in their roles could best communicate their professional strengths, limitations, and "growing edges" to other members of the team. In the words of

Mariano (1988), "security in one 's own discipline allows each team member the freedom to be truly interdisciplinary" (p. 286).

Research findings suggested that professional staff could mitigate or prevent health problems associated with loneliness or isolation by creating social networks and enhancing networks through the services of lay staff. Social support from natural or created networks helped disadvantaged women cope with stress, enhanced their knowledge and skills, and built capacities at the individual and small group levels. This finding related to social support networks is discussed through the experiences of participant women in HSMM, in Chapter 5. Collaborative partnerships with members of the natural or created support network facilitated the efforts of professional staff to take on primary health care roles. In the process, the roles of professional team members changed from expert to partner and facilitator. Concurrently, the status of the program recipients was elevated from the traditional role of patient or client to one of active and equal participant.

The findings presented in this chapter underscore Mariano's (1988) conclusion that interdisciplinarity is necessary as a "teaching method, learning experience, and practice orientation" (p. 285). They call for a better understanding of interdisciplinary collaboration including an explication of the barriers at the level of the interpersonal-team. Content presented in this chapter indicates that role confusion and/or conflict, decision-making practices, interpersonal communication, mutual respect, and perceived support were all key to interdisciplinary collaboration. Repeatedly, interviewees emphasized that effective interdisciplinary communication called on team members to share personal ideas and insights openly and to provide frank and constructive feedback. When differences surfaced, it was necessary for team members to individually and collectively engage in a thoughtful examination and consideration of differences. A climate of openness, mutual respect, and demonstrated caring and support, was critical. Additionally, adequate time for team-building activities was instrumental to effective team functioning, including regularly scheduled planning and de-briefing sessions, and All Sites Meetings.

CHAPTER 10

THE EMERGING ROLE OF THE COMMUNITY DIETITIAN IN HSMM

10.1. Introduction

This chapter provides an in-depth examination of the role of one member of the HSMM team--the community dietitian. The theme emerged from the research above and beyond the findings pertaining to the role of the dietitian on the interdisciplinary team. In contrast to Chapter 9 focusing on interdisciplinary collaboration, Chapter 10 deals with a new and emerging phenomenon related to the role of the community dietitian in HSMM.

In Chapters 4 to 9, The Empowerment Holosphere in HSMM is presented as the organizing framework for the case study research. In Chapter 10, the services provided by HSMM's dietitians are described as Intersectoral Action--the outer ring of The Empowerment Holosphere in HSMM (Figure 10.1). Although dietitians' services were also directed towards other spheres including personal care and small group development, the emphasis of the HSMM team was on intersectoral action, as discussed in Chapter 9. HSMM's dietitians worked as part of an interdisciplinary team to establish the horizontal and vertical linkages necessary to promote population health.

As in previous chapters, the content is divided into two sections. Section 1 focuses on the experiences of HSMM's dietitians who were attached to two HSMM sites --The Evergreen Community Centre and the Willow Community Centre. Two key informants who had extensive experience as community dietitians/nutritionists, and who were affiliated with CPNP programs across Canada, were also interviewed. Their insight into the emerging role of the community dietitian in HSMM enhanced the research findings by providing in-depth explanations of the beliefs, behaviors, and attitudes occurring in this phenomenon. Historical documents and artifacts describing the evolving role of the community dietitian in HSMM and CPNP have been included where appropriate.

The content in Section 1 highlights the ongoing confusion with respect to job title terminology in the area of community-based dietetics practice. Using research findings and the current literature on Gestational Diabetes Mellitus (GDM), an Integrated Model of Community Health Promotion (Laffrey and Kulbok, 1999) (Figure 2.2) is applied to HSMM. The goal is to examine how the emerging issue of GDM could be addressed by HSMM dietitians in disadvantaged communities. In highlighting the principles of health promotion, and in emphasizing aggregates and communities as clients, the model is relevant to the discourse pertaining to the emerging role of the community dietitian in HSMM.

Section 2 summarizes the theoretical constructs underpinning the research findings discussed in Chapter 10. The discussion focuses on the overuse of theories that define dietetic practice primarily in terms of a one-to-one relationship (i.e., dietitian-to-client/patient). The inherent conflict between these theories and the goal of promoting health through population-based interventions is addressed. Given a paucity of nutrition research employing theories focused upon the social world as a source of nutrition problems (Travers, 1997a, 1997b; Achterberg, 1992), the researcher reviewed the potential contribution of an alternate theory--critical social science. Critical social theory examines the social or environmental context of nutrition education research and practice.

The chapter summary outlines the major research findings related to the emerging role of the community dietitian in HSMM and links the findings to the theoretical constructs discussed in Section 2.

10.2. Section 1–The Evolving Role of the Community Dietitian

10.2.1. Intersectoral Action

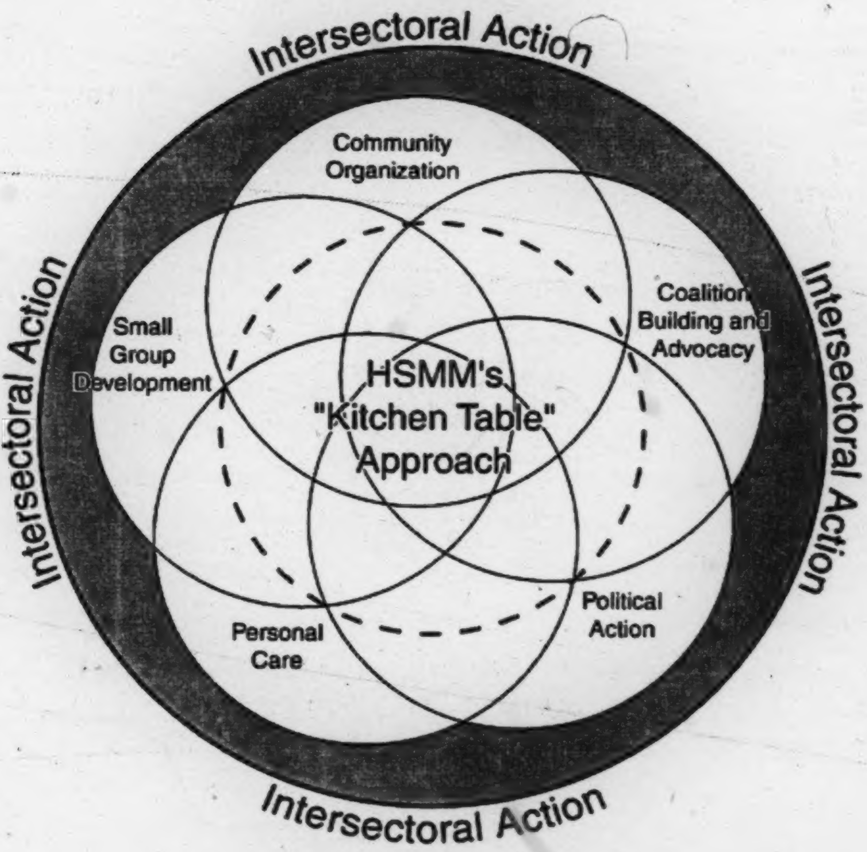

Intersectoral Action
Intersectoral Action
Intersectoral Action
Intersectoral Action
Community Organization
Coalition Building and Advocacy
Political Action
Personal Care
Small Group Development
HSMM's "Kitchen Table" Approach

Figure 10.1. The Empowerment Holosphere in HSMM (intersectoral action).

10.2.2. Confusion in Terminology

Boyle and Morris (1994) described community nutrition as a discipline that strives to improve the nutrition--and, by extension, the health--of individuals and groups within communities. They maintained that the ongoing confusion over use of "community dietitian" versus "public health nutritionist" stems partly from the traditional and somewhat distinct practice settings of community dietitians and public health nutritionists:

> Community dietitians, who are always registered dietitians (RD's), tend to be situated in hospitals, voluntary health organizations, worksites, and other non-government settings. Public health nutritionists, some of whom are RD's, provide nutrition services through government agencies. The public health nutritionist plans, coordinates, directs, manages, and evaluates the nutrition component of the agency's services. In today's practice environment, there is considerable overlap between these two designations, and practitioners in both areas share many goals, responsibilities, target groups, and practice settings. (pp. 20-21)

Boyle and Morris referred to all nutritionists whose major orientation is community-based programming as community nutritionists, whether their official title was community dietitian, public health nutritionist, nutrition education specialist, or some other designation.

Use of the terms--public health nutritionist, community nutritionist, or community dietitian--to denote the same or overlapping areas of community-based practice causes confusion for dietetics professionals, other health professionals, and the public. This lack of clarity contributes to role confusion among dietitians and nutritionists and makes it very difficult to accurately define scope of practice. This, in turn, poses problems for educators charged with developing community-based dietetics curricula at the undergraduate and post-graduate levels.

Dietitians in Canada are not alone in their struggle to accurately define the roles and responsibilities of community-based practitioners. Nurses are also engaged in a debate over the use of the term "public health nursing" and "community health nursing" to describe similar or overlapping areas of community-based practice. In an article entitled "Public health nursing or community health nursing: What's in a name?," King et al. (1995) maintained that the use of the term public health nursing and community health nursing caused role confusion among nurses and other members of the interdisciplinary community-based healthcare team. Further, King et al. stated that the role ambiguity complicated efforts to define the scope of nursing practice and to develop community-based nursing education curricula. They concluded that

> with the rapidly changing health system across Canada, and the trend towards consolidation of services and regionalization, an emphasis on home health care to individuals and families may overshadow health promotion and illness/injury prevention programs for population aggregates. We suggest that it is beneficial to use public health nursing as distinct from community health nursing to emphasize

> the focus on health promotion/injury prevention, one of the main principles of Primary Health Care. (p. 408)

King et al. (1995) also suggested that the use of public health nursing reflected two other principles of Primary Health Care--accessibility to health care, and intersectoral collaboration to address the social and economic determinants of health. According to the authors, use of the descriptor "public" denotes "general access for all citizens" and/or "openness and accessibility to all." This reflects the principle of Primary Health Care that all individuals will have access to the basic determinants of health and health services. Therefore, King et al. concluded that

> to emphasize the importance of the public health component of Primary Health Care services, it may be important to promote the use of the term public health nursing. Therefore, we suggest that community health nursing be used as the inclusive term for community-based nursing practice, including public health nursing, home care nursing, community mental health nursing, and occupational health nursing. Public health nursing would designate community-based nursing practice directed toward population-focused health activities in health promotion and illness/injury prevention. This practice includes services to individuals, families and groups, as well as community-level activities, such as community development and advocacy for health public policy. (p. 410)

While the nursing profession in Canada has yet to definitively address the question: Public health nursing or community nursing: What's in a name?, the findings of King et al. (1995) have increased nurses' awareness of the issue and the need to address the role ambiguity among community-based practitioners. The dietetics community in Canada is faced with a similar dilemma: Who are the nutrition professionals operating at the community level and what should they be called? What are the specific roles/responsibilities of community-based nutrition practitioners? What are the current and/or potential areas of overlap between community dietitians, public health nutritionists, and community nutritionists? Are the existing standards of community-based dietetic practice up-to-date and relevant given the present and expanding job market? And, finally, what should community-based nutrition education curricula encompass at the undergraduate and postgraduate levels?

[illegible].2.3. The Generic Role of the Community Dietitian

The Ontario Dietetic Association (1993) published a discussion paper on the "Evolving Role of Dietitians in Community Health Centres." This document highlighted the many ways in which community dietitians work with individuals, families, and community groups to promote healthy eating, to prevent disease, and to provide clinical support in the nutritional management of disease. A variety of approaches were called for including community development, advocacy, social marketing, self-help, peer counseling, health education and individual counseling (p. 4). The paper distinguished between the roles of public health nutritionists and community dietitians in stating that

> both do health promotion with respect to food and nutrition issues, but their target groups differ. In general, public health nutritionists provide programs to a more broadly defined population, whereas community dietitians are reaching out to a smaller local community, usually confined to a specific age or cultural group living within specific geographical boundaries. (p. 6)

The scope of responsibilities was described under the headings of Health Promotion; Direct Service; Education, Evaluation and Research; and Administrative Responsibilities. The specific health promotion functions of community dietitians in Community Health Centres (CHC) were defined by the Ontario Dietetic Association (1993) as follows:

- Participates in the development of multi-disciplinary health promotion programs by assessing needs within the community and planning and implementing programs which address those needs;
- Develops and maintains networks with community organizations and groups;
- Identifies barriers to food access and facilitates community initiatives to improve nutrition;
- Participates in health promotion policy development and advocacy at the health centre and at the community level;
- Obtains or develops, and evaluates, nutrition education resources to meet the needs of clients;
- Acts as a resource and technical advisor for health centre programs with a nutrition education component and for community groups (p. 16).

The authors of the 1993 report suggested that the role of the community dietitian would continue to evolve and that a broader health promotion approach would result in more intersectoral collaboration, increased interdisciplinary linkages, and stronger partnerships with community groups. Further, they predicted that there would be a higher priority placed on group activities including self-help groups and more off-site programming.

10.3. One Perspective on the Role of the CPNP-Dietitian

Community-based projects funded through the Canada Prenatal Nutrition Programs (CPNP) are required to include the services of a registered dietitian as outlined in the Canada Prenatal Nutrition Program, Guide for Applicants: "A registered dietitian must be part of the project planning team, and work with the ongoing training of staff and delivery of the program" (Health Canada, 1999a, p. 4).

A group of Saskatchewan dietitians, affiliated with CPNP projects, drafted guidelines to clearly define the role of the dietitian and to assist CPNP projects in ensuring the inclusion of the elements of a comprehensive prenatal nutrition program (CPNP--Saskatchewan, 1999, p. 1-2). The group recommended that a "letter of understanding," jointly developed by the CPNP project and the dietitian, be used to delineate the dietetic services to be provided. This letter could include, but not be limited to, the standards of service excerpted below:

- The dietitian is involved in the nutritional assessment process, which includes the assessment of dietary intakes and the development of nutrition recommendations;
- The program will provide the dietitian with sufficient information on each client in order that recommendations can be made regarding: dietary intake, vitamin and mineral supplementation, appropriate weight gain, nutritional implications of alcohol, tobacco and/or drug use (street or prescription);
- Vitamin/mineral supplements are provided to clients only upon the recommendation of the dietitian;
- The consulting dietitian provides written recommendations for each client whose nutritional assessment is completed;
- Nutritionally high-risk clients are referred for individual counselling by a dietitian. Examples include clients with gestational diabetes, eating disorders, other medical complications and clients with multiple risk factors;
- The consulting dietitian is involved in decisions of meal planning and food provision (e.g., cooking classes, snacks, and food supplements if these are part of the programming);
- The dietitian facilitates or provides input into nutrition education activities including cooking classes;
- Any nutrition education materials used in the CPNP program (e.g., videos and pamphlets) are reviewed and approved by the dietitian.

- The dietitian is available for consultation by CPNP staff regarding clients and other nutrition issues. (CPNP--Saskatchewan, 1999, p.2)

The condensed list of "standards of service" drafted by Saskatchewan dietitians who were affiliated with CPNP projects is in sharp contrast to the key functions of a community dietitian, published by the Ontario Dietetic Association (ODA) in 1993. The Saskatchewan group envisioned a very traditional role focused primarily on individualized counseling where the dietitian acts as a change agent, trying to help the "disadvantaged" cope with the critical nutritional issues associated with pregnancy. Interventions reflect a microscopic perspective in which the larger socioeconomic and/or political influences on nutritional well-being and food security are not considered. This traditional approach is based on nutrition education aimed at personal behaviour change--whether desired or initiated by the recipients and/or the health professionals. The expectation is that CPNP participants will adjust and conform to the existing system and its available resources rather than advocating for social change.

However, in describing a broader health promotion role for community dietitians, the authors of the ODA's report (Working Group of the Community Dietitians in Health Centres Provincial Interest and Practice Group, 1993) suggested that a community development approach uses strategies to enable people to take more control over and thereby improve their health. According to the ODA's vision, the dietitian assumes the multiple roles of advocate, technical advisor, and process facilitator. In comparison to the Saskatchewan document, the ODA's discussion paper recognized that the community dietitian is one member of the interdisciplinary primary health care team. The ODA authors maintained that a team approach, and the integration of services, improves the quality of community-based care and enhances the functioning of service providers through the sharing of knowledge and skills. This type of intervention, based on a community development approach, provides an opportunity to deal with the root causes of food insecurity and the broader issues which influence health. Further, the ODA position paper argued that community dietitians' use of health promotion strategies leads toward individual self-competence and community empowerment.

10.4. HSMM's Community Dietitians in Action

HSMM program documents submitted to Health Canada in 1998 included a job description for the "core staff" position of community dietitian/co-ordinator:

> Coordinating a city-wide collaborative prenatal nutrition/health program delivered at several sites, this flexible and resourceful individual will be responsible for all aspects of administration, communications, community marketing and supervision of the program and staff. . . . As the dietitian, the coordinator will participate in the initial assessment of participants (or delegate this to a participating registered dietitian). Follow-up support and counseling will be assigned to a staff peer counselor/outreach worker. While direct counseling to higher risk participants may be provided by the coordinator/dietitian, this is not a primary job function. (Healthy Start for Mom & Me, 1998, Appendix 1)

The "nutritional and other professional responsibilities" of HSMM's community dietitian/co-ordinator were listed as follows:

- Initial assessment of risk identification and needs of participants; involvement with development of plan;
- Coordinates counseling/support follow-up by staff or volunteers, assisting as necessary with high-risk women;
- Ensures nutritional standards and relevance of provided snacks and food activities;
- Ensures appropriate referrals and linkages to other community or medical resources;
- Acts as an advisor/consultant to related agencies, groups; provides in-service training on an as-needed basis (Healthy Start for Mom & Me, 1998, Appendix 1)

When reflecting on the partial list of job duties above, the researcher realized that the stated scope of responsibilities did not fully capture the HSMM's community dietitian/co-ordinator's personal experience of the role. Beth, the incumbent, described the challenge of explaining the untraditional nature of her work to family members. Immediately prior to joining the staff of HSMM, Beth had worked as a clinical pediatric dietitian in a local hospital:

> *It's very, very difficult to explain. Actually, it's funny. I was talking to my mom yesterday, and I've been with Healthy Start for a year, but I still don't think that she has a full grasp of what I do. It's so much easier to define yourself as a clinical dietitian: 'I go to the wards at these times,' where as with this job it's so different. I describe the drop-ins to her--I describe the layout of the program. And she says, 'So what do you get done there? What do you teach them?'*

Beth stated that in her work with HSMM she often drew on her experience as a child of immigrant parents. She felt that her childhood recollections helped to establish a connection with participants, especially immigrant/refugee women:

> *I came to Canada, from ______, when I was a year old. My parents couldn't speak English and it was a struggle for them. As a child, I had to speak on behalf of my parents because the language was definitely a barrier for them. That's why, for me, this is an ideal job. I know what it feels like to be an outsider. I know what it feels like when you're not yet accepted as a Canadian. I know what that feels like, so I try to make people comfortable. I want to introduce people to new foods because they're interested--they want to know what these foods are called in English, and how to make them. They want to assimilate a little bit into our culture. So, my heart is definitely there.*

Nan, the original community dietitian/co-ordinator with HSMM, and Beth's predecessor, explained that in past dietetic positions--both hospital- and community-based--she always felt as if she was *"talking to the converted."* In contrast, the population health approach employed by HSMM specifically targeted high-risk women and teens with the goal of reducing inequities in health. Hence, Nan felt that she was reaching the women who could potentially benefit the most from the services she had to offer. Nan, like Beth, felt that in her work with HSMM her life experiences converged with past professional roles:

> *I came to Healthy Start having worked both in hospitals and in the community. I really enjoyed the community work more--trying to reach people where they live. But, I never felt successful in reaching those who needed it. I felt that I was always talking to the converted, or to the people that needed what I had to offer the least. I taught prenatal classes for years, knowing that a lot of the women in those classes were healthier than I was. I always struggled with that--how can we reach people that might benefit from this more?*
>
> *Growing up, I saw a lot of poverty. I knew that people living in those situations had a great deal of strength and a lot of knowledge around food. And I saw them engage with health professionals, where we* [dietitians] *were perceived as the experts . . . that they somehow needed our expertise. I don't think that's completely accurate.*
>
> *I found in my work with HSMM that I had to suspend a lot of the traditional roles and assumptions and get out of the 'dietetics box.' By not thinking of myself as a nutritionist, but by grabbing everything that I knew about myself--my experience as a woman, as a mother, with poverty, whatever it was. My job with Healthy Start provided a place for all of these experiences to come together. I was supported and nurtured to use all of my resources to try to do my job. It felt honest and open as if, together, we were trying to re-invent family or*

> *community. Maybe it sounds really corny, but when you hear the expression 'it takes a village to raise a child,' I felt that we were trying to rebuild a network in the community to recreate and support the village--a village that could make broken families strong.*

In response to a question asking Beth to reflect on her initial involvement with HSMM, and her readiness to take on the role of a community dietitian, she recalled feeling fearful and anxious on attending a drop-in session for the first time:

> *I was scared. Are these women going to think I'm too young to be delivering this program? I haven't had enough experience; I haven't had children, what do I know? Those things were terrifying to me. Are they going to accept me? Will I be non-threatening to them? I didn't want to come across as being over the top and really pushy and say, 'You've got to make sure you gain this amount of weight.' I didn't want to do that, but, on the other hand, I wanted to show them I cared: 'I'm here for a reason, and these are the reasons that I'm here to help you, if you're interested.'*

Beth explained that she had serious doubts initially as to whether she was performing her role satisfactorily. She thought that unless she provided participants with all of the information that she had on a specific topic, she was not earning her salary:

> *As a dietitian, it was difficult, because you think, 'Am I earning my money? Am I giving everybody all the information that I have about calcium, or whatever?' Because, otherwise you don't feel as if you've done your job. I've really had to learn that it's by not giving all the information, and just giving those few points . . . that makes all the difference.*

Nan concurred with Beth that the community-based nature of the work was fundamentally different from the traditional role of a clinical dietitian. However, Nan expanded on this thought by suggesting that dietitians employed in traditional roles sometimes considered community-based dietetic practice inferior, or "fluffy work"--not the "real thing." Nan and Beth's comments imply that dietitians are socialized to value the scientific/technical knowledge associated with clinical practice over the more practical/interpretive knowledge associated with community-based practice. The idea of there being a "hierarchy" of dietetic practice, where community dietitians are ranked lower than their hospital-based counterparts, was a recurring concept that is discussed further in the following sections of the chapter.

In interviewing Nan and Beth, it was apparent that initially there was considerable role ambiguity related to the position of the community dietitian, within HSMM. This sub-theme is discussed in Chapter 9 focusing on interdisciplinary collaboration. There was also confusion in terminology related to professional job titles. In Manitoba, public health nutritionist positions are scarce and there is no legal protection over use of the term "nutritionist." Home economists, alternative medicine practitioners, health food marketers, and others with an interest and/or mandate in human nutrition, often refer to themselves as nutritionists. The title "dietitian," on the other hand, is the legally protected professional designation in the province. This lack of clarity contributed to the role confusion identified by research participants. Findings suggested that program staff, community partners, key informants, and HSMM participants used community dietitian, dietitian, and nutritionist interchangeably--in fact, it was not uncommon for an interviewee to use more than one designation in the same sentence.

In the following series of quotations, Beth briefly described her approach to the nutritional screening/assessment of HSMM participants. She stated that traditional approaches had been modified in keeping with the hectic work environment at the drop-in session:

> *When you have twenty-four women, you only have a limited amount of time to work one-on-one with all the women. I have a nutritional assessment that I try to fill out with all of the women, if I can. My goal would definitely be to get the nutritional assessments completed with all the women, but that's just* *not* *possible. If a woman comes only once to our drop-in, chances are that I won't catch her. I won't get it* [the assessment] *done with her.*
>
> *It* [the nutritional assessment] *is* *very* *different* [from an assessment conducted by a dietitian in a hospital]. *I've set it up in a way that if a woman has the literacy skills, she can complete it herself. I'm not measuring milligrams of calcium, or grams of iron, or anything like that. I'm looking at: 'How is she eating? Does she have some risk factors? Is she gaining weight? Is she taking prenatal vitamins? Does she have epilepsy? Does she have diabetes or anemia?' I try to assess quickly and as soon as I can. Those are the key things: 'Is she eating? Does she have food in the house?'*
>
> *What's the point of talking about meat if she doesn't have five dollars? It won't serve a purpose. If she's out of money, and she's hungry, I'll try to see if there's a way that I can connect her, for example, to the food bank in her neighbourhood. In a clinical setting, you tend to have more time than you do in a drop-in setting. In a drop-in, there's not much privacy, so you try to find a small little corner somewhere, off from everyone else.*

In the above series of quotations, Beth revealed that she was cognizant of the broader social environment and the economic forces that determined whether or not a participant made appropriate food choices. However, in referring the woman to the local food bank, Beth implied that she did not have the tools or the resources to single-handedly tackle the mother's food insecurity issues. HSMM's "Kitchen Table" approach, discussed in Chapter 4, afforded Beth an opportunity to use food "as a springboard to build access, skills, confidence, and social support of participant women" (Matheson & Wylie, 2000, p. 20). However, it is important to reiterate that HSMM was, at best, a short-term and limited solution to the food challenges faced by participant women and their families. As pointed out in the conclusion of Chapter 2, CPNP projects cannot compensate for serioulsly inadequate health and social programs that contribute to the poverty and social isolation experienced by marginalized women. Beth acknowledged this fact and she suggested that the food insecurity faced by HSMM participants was indicative of much broader insecurity in terms of access to a wide range of essential resources and health/social services.

HSMM's Collaborative Outreach Model (Appendix C) indicates that the majority of dietitians contributing services to the bi-weekly HSMM drop-in sessions are employed by hospitals and/or community health centres, and their day-to-day practices have a strong clinical, as compared to a community, orientation. Beth suggested that her professional peers employed in hospitals or other clinical settings were intrigued by HSMM, specifically the untraditional and interactive nature of her work:

> *I think other dietitians are quite intrigued because it is so different. I think it's really hard for a lot of people to get their head around the concept of doing nutrition from a different perspective. I know dietitians do it, but it's more one-on-one, and it's not as interactive as our drop-in sessions are. Dietitians ask a lot of questions; 'How would you do this?' or 'How do you manage such a large group?' Because, if they* [dietitians] *are doing educational sessions, they're usually in a classroom type of setting.*

Beth went on to explain that experienced clinical dietitians providing services at the HSMM drop-in sessions required a lot of support and direction because the community-based role was so different from what they were accustomed:

> *I think it's been very challenging for the dietitians that contribute to our drop-ins, because the work is so different. It's not something that we're ever trained to do.*

> *The dietitians look forward to coming to the drop-ins. It is different from what they do every day--the one-on-one counseling. They look forward to coming to HSMM. You can see it in their faces when the baby's born healthy, and at a good weight . . . you can see that the dietitians are proud when the mom and her baby come back to the program.*
>
> *We offer them* [dietitians] *lots of support. We let them know that it's an evolution; 'We don't expect that you're going to be good at this right from the beginning,' because it doesn't usually happen that way. Most people don't have the gift to just go to the drop-in and to connect with all of the women right away. It just doesn't happen that way. Time helps, for the women to get to know you, and for you to become more comfortable with the material and some of the nutritional issues that are important to talk about in pregnancy. There aren't many clinical dietitian positions that deal specifically with prenatal nutrition. Dietitians coming to Healthy Start have to start boning up on that quite quickly.*
>
> *We have developed a nutrition resource binder containing some of our key nutrition messages and some of the resources that go along with them. It's all in one binder for them* [dietitians] *to use as a tool to help them plan for the next drop-in. But we really encourage them not to use an overhead* [projector], *to make it more interactive--just talk to people, talk as one woman to another woman.*

Judy stated that not all dietitians have the aptitude, nor the personality, for the specialized nature of community-based work. She considered flexibility, openness, a non-judgmental attitude, and *"insight into the lives of participants"* as key attributes. Judy's comments underscored the importance of community dietitians beginning critical research with the lived experiences of participant women. Otherwise, there is a gap in the knowledge base of many dietitians that relates to the complexity of the social world and the forces that shape the nutritional health of a population. Reutter (2000) commented that nurses, also, must critically examine "the *context* of health behaviours, rather than focusing solely on the behaviour itself" (p. 183). Or, as Wilkinson (1996) concluded, "to change behaviour it may be necessary to change more than behaviour" (p. 64).

Judy elaborated on the requisite attributes for community-based dietetic practice:

> *I think it really does take a special person--a person who is very flexible, and one who has a lot of insight into what makes a difference for people, what makes a difference for women. Just to give you an example, we had a gal* [a dietitian] *that came to a drop-in, and it just was not an area that she was comfortable with and she really didn't have that kind of insight. So she came, and she was watching me, and she was watching the other professionals and watching the women, and when she left she said, 'I just don't get it. As far as I can see, nothing happened at this site because women came, and they were milling around and I don't see any of the benefits; I don't see that anything came out of it.' But the insight is that the*

> *women are coming, and as they come in the door of the drop-in session they make eye contact with you, and they will ask you a question.*

Nan agreed with Judy that, for the most part, *"dietitians don't come out of school ready for this type of work."* She explained the process that she used to recruit dietitians to provide services at the bi-weekly HSMM drop-in sessions:

> *We had some really excellent dietitians. I knew that the training wasn't always there for what they* [the dietitians] *would be doing with Healthy Start. I knew that if she* [the dietitian] *wasn't judgmental, had a big enough mind, and was warm, that the participants would receive her well--that the women could relate to her.*

Mary, a professional social worker, described how she observed the dietitians and nurses "shed their cloaks" of professionalism over approximately a six-month timeframe. She maintained that in order for the professional team members to successfully connect with participants, it was necessary for them to learn new, innovative, and untraditional approaches to community-based practice:

> *I see with the professionals, after about six months, they're really getting into this nonprofessional 'stuff,' because they see that they're able to get information to moms in a way that they couldn't before. It takes practice, because it's hard to let go of those things. We're taught how to be professional, and we revel in our professionalism.*
>
> *How do we learn to give it up? That's an interesting question. You have to see it 'in action' somehow. When you see the public health nurse laughing--talking with a mom, down on the floors with the mats, or playing a game--and they see the moms responding, see them learning, and see moms pulling out of themselves and actually laughing and participating. I think laughter is one of the ways we open our heads to learning.*

Mary stated emphatically that the traditional "lecture" approach to conveying information did not work in the drop-in setting. She explained the participants' reactions:

> *But you know what the moms do--they don't listen. They make little conversations among themselves. They've done this to all of us; that's how they tell you that they're just not interested. So, somebody's doing a presentation with their charts, and their written stuff and everything, and the moms go, La-da-da-da-da. They look at the flip charts, and then they turn to their neighbour and they say, 'So what did you do last night?' And then all these little conversations break out in the group. It must be devastating to the presenter.*

In response to a question asking Mary how she prepares professional team members for their roles at the drop-in session, she provided examples of the "tips" that might be helpful:

> *I suggest that they just stick to a couple of little points. I remind them we have the whole year* [to work] *with this mom. A couple of little points, then you want to try to get them telling you what they know already, because they know a lot of stuff. Try to get one mom talking to another mom, which is more meaningful to the second mom, than coming from you. Or say, 'Wow! That's really neat! That's a really good idea. Did you all hear that? _____ said that she found holding the baby this way to burp the baby really worked. How many of you have tried that?'*
>
> *Talk about your own experiences, your own child, and what your child doesn't like. That's totally taboo, right? We're taught never to bring yourself in. Well, hell, who's going to listen to you if you don't bring yourself in? You're a person. You're a woman who's done that. You live with children, you experience the same things they do. I tell them about some of the dumb things I've done. You have to make yourself real-- you have to be a real person.*

Mary concluded her answer by raising an interesting issue that had recently come to her attention at a drop-in session:

> *Another issue, and yet another eye-opener for us. This is the use of the word 'should,' and making judgmental statements, even so gentle as, 'You should be cautious about that.' It is so interesting to watch the moms' body language go from open to defensive and then they no longer hear what is being presented. Very interesting!*

The above quotations from Beth, Nan, Judy and Mary begin to describe the emerging role of the community dietitian in HSMM. The practice reflects a population health approach that facilitates empowerment by "starting where the people are" (Labonte, 1994, p. 31). The dietitians' actions signify a shift away from traditional health promotion practice characterized by professionals who manufacture need, create deficiencies, and define solutions (McKnight, 1995). The HSMM dietitians assisted participant women in identifying their own concerns--they respected and accepted the women's agenda at the drop-in sessions. The dietitians convincingly demonstrated that they valued and respected differences in perspectives as well as the capabilities, strengths, and existing resources of individuals and communities (Israel et al., 1994).

10.5. Using Food to Get to Nutrition

Chapter 4 focuses on HSMM's "Kitchen Table" approach describing how team members used food and nutrition as a springboard to build access, skills, confidence, and social support of participants. This section discusses how dietitians working in a community-based setting have come to embrace the concept of using food as a tool to "teach" HSMM participants about nutrition. Research findings suggested that this is a brand new concept for dietitians and that the food-focused role of HSMM's community dietitians has challenged the traditional norms and values of the dietetic profession.

Dietitians of past eras may not have been challenged by HSMM's food-focused approach to nutrition education. It is interesting to note that nutrition education's early roots were in home economics which employed an ecological approach to improving the quality of people's lives (Kolasa, 1981). According to Travers (1997a), the field of nutrition became more scientifically oriented over time and increasingly preoccupied with "translating scientific knowledge into recommendations and disseminating them" (p. 57). As scientific knowledge came to the fore of the dietetic profession, less and less emphasis was placed on food--more specifically, the role of food in the social world. Given that nutrition education is concerned with changing food-related behaviours, Travers (1997a) argued that "it was necessary to explore the meanings that people give to food, nutrition, and health and the values placed on these in relation to other valued pursuits in life" (p. 58).

Victoria, who represented the program's sponsor (Dietitians of Canada) on the HSMM Steering Committee, described her perceptions of the learnings acquired by dietitians who provided services at the drop-in sessions. In the second quotation, she implied that dietitians fulfilling the role of scientifically trained "nutrition experts" have somehow distanced themselves from food:

> *I think for them* [dietitians] *the learning is related to the interdisciplinary work with nursing and appreciating the role of peer outreach. They don't have difficulty with understanding the prenatal nutrition piece, but the big learning that I see happening is the approach--how the nutrition message in HSMM is delivered? When I speak about it* [HSMM] *to dietitians, they say, 'Oh, yes.' But, it's not until they have actually experienced it that they see how different it* [HSMM's approach] *is from traditional dietetic practice.*

> *Understanding the meaning of food, how accessing food, and basic food preparation are such important parts of the nutrition message. I think that nutritionists tend to sometimes get caught up in the lecturing: 'Here's healthy nutrition.' But, surprisingly, the nutrition message isn't tied to food very often.*
>
> *I also think that they* [dietitians] *are very moved by the moms' experiences, and that they internalize that in their practices. I've often heard the HSMM dietitians say; 'I learn so much more than I feel I give.' And, they become more empathetic. Dietitians wouldn't have gone into this profession if they didn't have some streak of that anyway, so I think that their experiences with Healthy Start build upon the best of nutrition practice.*

Nan suggested that as clinical dietitians moved out into the community they gained a better appreciation of the context of participants' lives. In the process, they tended to become less judgmental and more sensitive to other world views. In the second quotation, she described how HSMM participants had traditionally been labeled by service providers as *"noncompliant."* This is consistent with a conservative scope of practice where psychologic theories are used to explain patterns of health and health care. In this traditional mode of practice, poor compliance, missed appointments, and reluctance to participate in treatment plans are all attributed to motivation or attitude problems on the part of the client (Butterfield, 1990). A dietitian who views the world from this perspective does not even consider the possibility of working to alter the system or empowering the client to do so. Nan explained:

> *If (and that's a big if), a participant came to see you as a hospital dietitian and you have an opportunity to do a one-on-one* [counseling session] *with her, would you ever come to know her life in the full dimension? I don't think so. . . . You don't get to know her, or her food choices, in context. It's amazing how when the dietitians see it all in context, or her nutrition in context, it's amazing how you see them relax. The dietitians know this woman is grappling with some other issues as well, and that those issues are not all in our territory. They* [the dietitians] *become more supportive and realistic--more understanding and less judgmental.*
>
> *The program was built in a way that would remove as many barriers as possible for women to participate. But, you don't even realize until you get out of a medical institution or clinic how many barriers there really are--physical, economic, psychological barriers--for women to overcome. So, these women had traditionally been labeled as 'noncompliant,' or, 'no-shows,' . . . I think that the HSMM dietitians enjoyed being able to get out of the hospital--take off their lab coats--and just go in there* [the drop-in session].

Victoria reflected on an earlier conversation she had with a dietitian providing services to HSMM. According to the dietitian volunteer, HSMM had provided her with an opportunity to gain "real world" experience--the kind of experience that was impossible to obtain in an artificial classroom environment:

> *This young dietitian was telling me about herself, that there's a whole world out there that she didn't know anything about. And as professionals, unless we get right out there in the community, we're never going to learn about it. You can read all the textbooks you like, but it doesn't tell you what it is really like. About what the community itself is like, what community development is really all about, what the lives of the moms in the program are really like.*

Sarah, the program manager, concurred that many of the clinical dietitians involved with HSMM welcomed the change-of-pace that accompanied community-based practice. Like Victoria, she suggested that the most dramatic shift for the dietitians involved the program's emphasis on food and on interdisciplinary teamwork:

> *My impression is that this has been a great opportunity for some dietitians, . . . even beyond those who are actually involved. There seems to be a real curiosity, intellectually as well as emotionally, about what it means to work in the community and not wear a lab coat and not do what do they call those... meal plans or meal charts or food charts? Those twenty-four hour recall methods, which we don't use. HSMM provides an opportunity for the dietitians to try something else, completely different.*
>
> *A new role perhaps? Being a person who personifies the link to food, and the love of food, and the critical role that food plays. Yet, still learning how is the role of the dietitian different than that of the nurse, because we've had those situations here where nurses feel, 'I know about nutrition, so why can't I do everything,' in a sense.*

Nan agreed with Sarah that a fundamental learning related to the power of food in mobilizing a community around common issues or concerns. In the first quotation, Nan suggested that her professional training to date had focused exclusively on the "science" of nutrition. She identified gaps in her knowledge base related to the "art" of delivering population-based nutrition messages. Nan expressed her frustration with dietetic practice that focused strictly on the individual, realizing that it often contributed to victim blaming (Travers, 1997a). In the second quotation, Nan described food as an *"entry point"* to a community-based comprehensive prenatal program:

> *I came from a background where I had the scientific knowledge--the understanding that your nutritional state is a critical determinant of your health and the outcome of your pregnancy. I sometimes think that the* ***science*** *of nutrition has been considered more important that the* ***art*** *of nutrition. I always knew that the science was important and yet I've been frustrated by knowing that it's not enough to tell people that they have to eat well when you know that they don't have the resources to do it.*
>
> *So, in my work with Healthy Start, I found that food was a really important entry point to build a prenatal program on. Nutrition, distilled to its perfect essence, is food. And food has an incredible power to mobilize a community. And who better* [than dietitians] *to have out in the community, using food as a vehicle to connect with people? Dietitians have the scientific understanding, they know the role that food plays.*

In the above quotation, Nan was confident that dietitians know the role that food plays in health. Further, she was adamant that there is a viable role for dietitians in the community. However, Nan may have overestimated dietitians' present capacities in *"connecting with people"* at a community-level. Research findings related to HSMM suggested that the role of food in mobilizing a community around priority issues/concerns is just beginning to emerge. Because the presence of the community dietitian in Winnipeg was so new prior to the launch of HSMM, experienced community practitioners considered dietitians the "new kid on the block." This issue is addressed in Chapter 8 on Community Organization. A major finding related to the positive outcomes associated with highly skilled community developers working collaboratively with dietitians in the early stages of program planning and implementation.

In making the transition from the hospital to community, Beth suggested that it was important for her to relinquish, or *"give up,"* some of her "expert role" in nutrition in order to connect with participants and interdisciplinary team members in a meaningful way:

> *I think that sharing back and forth--about nutrition and about food--is something that I've had to learn. A lot of people think that they are experts on food and nutrition, because everyone eats food, everybody knows a lot about food. So, it's really having to let go of that a little bit and* ***not*** *saying; 'I know everything about nutrition and no one can tell me anything else.' It's really about letting go a little bit, and that's hard, because we're been trained to be the experts. But, in the end, the rewards outweigh what you let go, and you learn so much more from opening yourself up.*

Nan suggested that there was a hierarchy in the dietetics profession with clinical dietitians being at the top. She called for a shift in dietetic education and training from a microscopic to a macroscopic perspective. A "big picture" perspective would examine the broader socio-economic environment as the source of many nutrition inequities and concerns (Travers, 1997a, 1997b; Kent, 1988). Nan emphasized that HSMM had given her an appreciation of the social value of food. In the process, she learned more about the meanings that marginalized women gave to food, nutrition, and health. In the following quotation, Nan implied that she valued her experience with HSMM because it afforded her an opportunity to synthesize her professional knowledge of nutrition with her personal experiences related to food:

> *There's a kind of hierarchy in our training in a way. It sounds like I'm being really hard on dietitians, and I don't mean it as totally negative. To be credible in a field, you do have to get a good grasp of biochemistry and physiology and a whole lot of things and you do have to understand nutrition on a micro level. But, sometimes when you break food down into its micro components, you lose sight of its social value. I think many of us* [community dietitians] *have had to rediscover that food is important, too—not just nutrients. I think that Healthy Start, and its emphasis on food, provided dietitians with an opportunity to celebrate the social value of their work, because food is ultimately the vehicle to pull together all the micronutrients and their impact on health. Healthy Start is a place where people easily relate to food. So that was good, it made you feel good about your profession, your knowledge, and your experience.*

Nan and Beth agreed that it was important to focus the discussion at the drop-in sessions on food, rather than nutrients. However, in the second quotation below, Nan cautioned that there was a risk involved in "reducing" the discussion to the lowest common denominator--food.

> *When you talk 'food,' you tend to relate more as equals and less as 'experts.' Food makes dietitians more approachable to participant women. It makes them 'human,' whereas these women may have perceived the dietitians as naïve or unrealistic before. When you talk calcium or something, all of a sudden, it can distance you.*
>
> *There is a risk, though. When I was able to let go a little bit, and not focus on the science of it, by saying, 'This is food, this is where we can meet' there is a risk there that you have to be aware of. The part that I probably didn't emphasize enough, was what I had in my back pocket--the nutrition piece. What you have in your back pocket is vital, and you have to listen astutely and know when your 'science' is needed. You need to know when your 'expert' knowledge is needed,*

> *so you can plug it in. People can reduce nutrition so far down to just the food part, that anyone can do it. And I think that you lose a lot when you lose the nutrition perspective.*

In retrospect, Nan felt that while HSMM's food-focused approach was important and effective, it was critical for dietitians to keep their nutrition knowledge and expertise *"in their back pocket."* She implied that knowing how and when to *"pull it* [the scientific knowledge] *out, and put it on the table"* was an art in itself, and a skill that developed over time:

10.6. Gestational Diabetes: A Case in Point

This section provides an overview of how the emerging issue of Gestational Diabetes Mellitus (GDM) within disadvantaged communities is being addressed by HSMM's dietitians. GDM can place the mother, infant, or subsequent generations at risk for abnormal glucose and insulin control, with the related risks of obesity, hypertension, and diabetes (Jovanovic, 1998). Pregnancy represents a window of opportunity for dietitians to work collaboratively with women to achieve as "normal" a metabolism as possible, before, during, and after each pregnancy. Rather, than focusing on the multi-faceted "Kitchen Table" approach discussed in Chapter 4, the focus of this section is on the evolving role of HSMM dietitians in addressing the clinical issue of GDM in an informal community-based setting.

An HSMM peer outreach worker (Alice) recalled her past personal experience with GDM. She reflected on her lack of understanding of the implications of GDM and the ineffectiveness of the dietary counseling she received:

> *Your doctor doesn't sit and talk to you about how you're eating, and the impact of the food you eat on your baby later on. They told me that my blood sugars were too high, that I didn't have to go on to insulin or anything, I just had to have a diet. So, I went to a dietitian at the hospital. I talked to her and she told me, 'This is sort of what you have to eat,' and whatever. But it was sort of like, okay, I'll try that, but I really didn't stick to it like I should have. From what I know now, it would be different. It was just like, 'Go on this diet, and try not to eat sweets.' She didn't tell me how important it was to follow this diet. To me, it was no big deal. She made it sound like you eat small meals, and eat this and this. And a lot of the food on there* [diet instruction sheet] *I didn't really like, and I didn't feel comfortable telling her that.*

In contrast to her personal experience described above, Alice outlined the HSMM approach to a participant woman recently diagnosed with GDM:

> *Girls are coming to our program with gestational* [diabetes]. *It's just explained to them a lot differently and in more depth, and you have time to meet with the dietitian and really talk about any questions you may have. Beth* [HSMM dietitian] *has even done home visits, which I think is really, really neat. She could actually go right in the home and talk to this mom if she wants her to. I think it's more personal. Beth sort of knows what situations they're in and what they can afford and what they can't.*

Beth, a HSMM dietitian, explained that her busy schedule, competing pressures, and HSMM's overwhelming success in attracting participants to neighbourhood sites, resulted in her doing home visits on an as-needed basis. She described her role at a drop-in session, acknowledging that it may be very difficult for someone unfamiliar with HSMM's "Kitchen Table" approach to grasp the basic concepts:

> *You physically almost have to see it to understand and really get a sense of what it feels like to be there. It's not formal teaching. I don't use an overhead* [projector]. *I don't lecture. I don't do one-on-one clinical work with every single person that comes in every single time. It's really women sitting down, talking, sharing the things that I've learned and the experiences that I've had with pregnancy, nutrition and pregnancy, and also having the team members share their experiences.*

Judy, a community dietitian, spoke at length about GDM. She described the initial fear and ongoing challenges experienced by many participant women with GDM as their contact with healthcare professionals increased. She stressed the important role that HSMM played in encouraging and supporting women with GDM to seek appropriate treatment:

> *We've had some moms, for example, with gestational diabetes, that have had to go on insulin, where it's very difficult for those moms because of the time they have to spend with health professionals. It's just been a real exercise for us at Healthy Start to talk as much as we can with those women about what's happening in the health-care system and encouraging them to be persistent about attending their appointments, and their doctor visits, to have their insulin increased, to have the ultrasound and stress tests and all of the things that we sort of accept are necessary that are really difficult for women, as they get towards the end of their pregnancy, almost every day they need to be doing something different.*

Judy drew on the experience of a HSMM participant's progress in dealing with GDM in her second pregnancy, as compared to her first:

> *We had one gal who really struggled with that* [insulin injections] *a great deal in her first pregnancy that she was with us. But, by the second time around, she was living closer to the hospital intentionally so that she would be able to get care more easily. She really did make a lot of changes so that she could adjust. So, we did see where the program really helped her to have better contact and better health care. And earlier.*

Beth recalled a HSMM participant's escalating frustration related to the prescribed dietary management of GDM. She reflected on the lessons learned in working collaboratively with this HSMM participant:

> *I worked with one woman who had gestational diabetes with her first pregnancy. After the baby was born she developed type 2 diabetes, and then insulin diabetes. Now she's pregnant again but does not want to talk to me about it at all. Her physician is following her, but she's not really on any type of diet plan. Her blood sugar is all over the place right now. She told me, 'I know what I have to do. I've done this before, but I'm just frustrated. I want to be like everyone else. I want to eat like everyone else.'*

In working with this HSMM mom, Beth explained that she had learned to "back off" and to respect what the woman wanted to know and, in fact, already knew about GDM: *"She knows I'm there for her if she ever needs me. It's hard though, because you want to say, 'Okay, I'm going to tell you everything you need to know'* [about GDM]*."*

Accessing a dietitian through the traditional health care system is difficult, and Judy questioned whether many of the HSMM participants would persevere:

> *People come in to see the doctor and often spend quite a bit of time waiting, not in the waiting room, but in the clinic, actually having blood taken and all of the things that you have to do when you come for your prenatal visit. And, the nutrition person is added on top of that, and so sometimes, they* [HSMM participants] *have just had enough. They don't always identify the dietitian as a professional that they want to see. They know they want to see the doctor, and the nurse is sort of understood in that, but the dietitian is not necessarily identified as the person they want to see when they come into the clinic, so they might not get into my office.*

10.6.1. Application of an Integrated Model of Community Health Promotion

In application of the model, illness care, preventive care, and health promotion care began at the community level and moved to the individual. Table 10.1 suggests specific roles and/or interventions that a community dietitian could select for each level of client.

Table 10.1

Community to Individual: Gestational Diabetes Mellitus (GDM)

Focus of care	Community	Aggregate	Family	Individual
Illness care	Assess community for accessibility and adequacy of care for women with GDM	Assess prevalence of GDM in the community Develop informal "classes" for women with GDM and/or include information on GDM at HSMM drop-in sessions	Teach early detection of GDM/ type 2 diabetes in high-risk groups and families Support family in making appropriate dietary/lifestyle changes	Encourage recommended prenatal care/ monitoring of GDM
Illness/disease prevention	Conduct a targeted community assessment re beliefs and norms about GDM/type 2 diabetes	Participate with other health practitioners and lay staff re prevention and control of GDM/type 2 diabetes	Support family in anticipatory guidance GDM/ type 2 diabetes	Teach beneficial effects of diet/ lifestyle changes on prevention and control of GDM/type 2 diabetes
Health promotion	Hold discussions with women, community leaders and other sectors re the health-related issues/ needs of the community	Participate in planning and implementing appropriate and accessible community-based programs healthy eating and active living	Plan with family to incorporate a healthy lifestyle	Empower individual to adopt a healthy lifestyle

Note: Table 10.1 is based on material presented by Laffrey and Craig (2000, pp. 105-125).

The suggestions pertaining to health promotion, disease prevention, and illness care in GDM are elaborated upon below. The research findings related to GDM indicated that the HSMM's dietitians targeted some client systems and levels of care more than others. For example, broad-based diabetes prevention initiatives involving the entire community were not yet a reality. Present areas of emphasis included illness care and GDM prevention interventions targeting individuals, families, and aggregates attending drop-in sessions. It is important to acknowledge that the dietitians' work was seriously curtailed by the scarcity of community-based positions in Winnipeg. Further, the direct involvement of dietitians who contributed services to HSMM was limited to the bi-weekly drop-in sessions. In the description of community dietitian interventions below, a distinction is made between present and potential roles, related to the issue of GDM in disadvantaged communities.

10.6.1.1. Illness Care

Potential strategy--at the community-as-client level, dietitians participate with other health professionals, the Winnipeg Community & Long Term Care Authority, and Manitoba Health in an assessment of the community to determine the accessibility and the adequacy of care for disadvantaged women with GDM.

Present strategy--from an aggregate-as-client perspective, community dietitians assess the prevalence of GDM in the HSMM population and work with team members to include needs-based information specific to GDM at the bi-weekly drop-in sessions.

Present strategy--family-as-client care includes increasing awareness of the early signs and symptoms of GDM in high-risk groups of participant women and supporting families in making the necessary dietary and lifestyle changes.

Present strategy--in the provision of individually-oriented care, HSMM's dietitians encourage and support participant women with GDM to obtain regular prenatal care.

10.6.1.2. Illness/Disease Prevention

Potential strategy--an initial step at the community-as-client level is to assess the norms, beliefs, and attitudes about diabetes (GDM and type 2) in the Winnipeg community. Diabetes prevention initiatives must be congruent with the world views of community members and consistent with the values of families, schools, churches, and other community-based agencies/organizations. "Starting with the community" ensures that the program is culturally acceptable and the priority issues and concerns are addressed (Labonte, 1994).

Potential strategy--aggregate-as-client includes working collaboratively with other practitioners and lay helpers to develop diabetes prevention programs targeting community organizations, including schools. Families would also benefit from anticipatory guidance on GDM and type 2 diabetes. In some situations, this may include appropriate dietary/active living counseling for high-risk situations.

Present strategy--at an individual level, the community dietitian "teaches" HSMM participants about diet and lifestyle changes and facilitates follow-up care in hospitals and clinics on an as-needed basis.

10.6.1.3. Health Promotion

Present strategy--health promotion is the broadest and most complex focus of care. Within HSMM, health promotion is provided by the community dietitian with each level of client. However, as pointed out earlier, the dietitians' efforts in the realm of broad-based health promotion are seriously limited by both time and staffing resources.

In HSMM, dietitians collaborate with community leaders, participant women, and other sectors. Consistent with a population health approach, HSMM includes the following elements: (a) community initiation of the program and continuous involvement in it; (b) awareness of the determinants of health; (c) formation of partnerships with existing groups in the community; (d) ongoing long-term support rather than a one-time or short-term intervention; (e) flexibility of the program to meet different needs; (f) making the intervention part of daily life rather than a special activity; (g) promotes and supports individual responsibility for self-management; (h) offers financial and human resources to initiate new programs; (i) makes changes in the physical environment which promote healthy lifestyles, such as increased availability for good food and safe places for physical activity. (Saskatchewan Health, 1999, p. 5).

Present strategy--at a family-as-client level in HSMM, dietitians plan healthy activities including well-balanced meal planning and to a lesser degree physical activity.

Present strategy--at an individual-level in HSMM, the dietitian supports and encourages individuals to adopt a healthy lifestyle.

Laffrey and Craig (2000) have pointed out that nursing roles in health promotion are similar to those suggested for prevention and illness care. However, as the practitioner focuses on the aggregate and the community the roles of social marketing, community development, and policy formulation become more pronounced.

The progression of roles and interventions illustrated in Figure 2.2 (An Integrated Model of Community Health Promotion)--starting with individual care and moving to the community--corresponds to the "levels" of The Empowerment Holosphere in HSMM (Figure 10.1). The holographic model depicted in Figure 10.1 presents a series of overlapping spheres beginning with Personal Care and progressing to Small Group Development, Community Organization, Coalition Building and Advocacy, and Political Action. The intersectoral actions of HSMM's team members are depicted on the outside ring of the Holosphere. These actions include a range of strategies and approaches represented in spheres 1 through 5. HSMM's "Kitchen Table" approach, discussed in Chapter 4, is positioned as the central construct linking all five "levels" of The Empowerment Holosphere in HSMM.

10.7. Contribution of HSMM's Food Preparation Volunteers

Interviews with HSMM team members and key informants suggested that the food preparation student volunteers, from the University of Manitoba (Foods and Nutrition Department), played a vital role in the operation of the bi-weekly drop-in sessions. Given the significance of their role, it was surprising that the volunteers were not represented on the HSMM Collaborative Outreach Model (Appendix C). A recent edition of HSMM's Bulletin listed the student volunteers and thanked them for their contribution to the program. Direct observation of the drop-in sessions at two HSMM sites--The Evergreen Community Centre and the Willow Community Centre--provided an opportunity to watch the student volunteers "in action." Additionally, one food preparation volunteer (Dorothy), "attached" to the Evergreen Community Centre site agreed to being interviewed, as did the HSMM staff member responsible for coordinating the student placements.

Judy stated that the food preparation volunteers made a significant contribution to the drop-in sessions. Without their assistance in preparing and serving the snack, the dietitians would have had to assume responsibility for this time-consuming task. This would in effect reduce the amount of time available to the dietitians to spend with participants:

> *It is a real challenge for dietitians, because you need to be able to attend to very specific parts of the program--like the food--and it's hard to let go of that. The volunteers, now that they're experienced, are coming in and they're doing a great job. So, for the last little while I've been able to let go of that. I know that it* [the snack] *is going to come out of the kitchen on time and that it won't be burnt because I got talking with someone just at the time it was supposed to come out of the oven. I've been able to relax about that with the really good volunteers that we've had.*

The HSMM staff member (Louise) who had direct responsibility for coordinating the student volunteer placements provided some background information:

> *There have been some first- and second-year students who have called to say that they are interested in volunteering. However, the majority are in fourth year--students who will be applying for a dietetic internship. How do we recruit? We do a poster at the university in all the areas where the students hang out. So, in the Common Room we have posters made up, or we've got little tabs where you just pull off the number. Also, professors sometimes made announcements that, 'If you're looking for volunteer opportunities, here are some places,' and Healthy Start would be listed as one.*

In response to a question asking Louise to describe what the HSMM volunteer position entailed, she stated that

> *it's called a food prep. volunteer. And we require the volunteers for every site--for the prenatal as well as the post-partum drop-ins. The commitment on the part of the student would be one afternoon--two to three hours every two weeks--or it can be every week, if the student has time. It's really whatever their schedule allows.*
>
> *I describe the overall nature of the program; the drop-in sessions, the concept of that, and how many drop-ins we have, and who's at the sites--the public health nurses, dietitians, and peer support. I go into what happens at the drop-in sessions, that we always provide a snack and how important the snack it is. Then we talk about the role of the food prep. volunteer.*

Louise referred to a handout included in an orientation package provided to new food preparation volunteers. The specific responsibilities were listed as follows:

- Prepare Meal Bag and snack for the designated times;
- Arrange utensils and dishes for serving
- Clean kitchen--this includes washing dishes, putting dishes away, cleaning counter tops and stove
- Communicate with dietitian regarding any challenges or issues
- Support participants if they want to help with meal preparation
- A minimum of 24 hours notice notification is required if unable to attend the drop-in
- Assist other Healthy Start team members as needed (Healthy Start for Mom & Me, 2000, p. 1)

Depending on the site, the volunteers provided a large snack for 20-40 adult/teen participants, and a smaller snack for the toddlers in attendance.

In response to a question asking Louise if the volunteers had an opportunity to observe the drop-in session, she replied that

> *I tell the students that if there is some 'down' time, or if they work it out with the dietitian, they can have an opportunity to observe what goes on at the drop-in. As time progresses, if there's other needs, they may be asked to fill those needs at the drop-in; it could be holding babies, things like that.*

Louise again referred to the food preparation volunteer orientation package and removed a handout entitled "Healthy Start for Mom & Me Confidentiality Agreement." She explained the purpose of the agreement:

> *The other thing that we go through is a Confidentiality Agreement. I explain this to them, because they do overhear conversations that may occur with dietitians, or nurses and participants. And occasionally when they're cleaning up, if it's okay with the team, they are welcome to sit in on a de-brief session. So, anything that they do hear and any information that is discussed is confidential, and that they should not disclose any names of participants or issues with anybody outside of Healthy Start and that it's very sensitive and can only be passed on privately with a Healthy Start team member.*

Dorothy, the student volunteer at the Evergreen Community Centre site, recalled her first day at a very busy drop-in session:

> *I was a little nervous because, first of all, I'm not familiar with Winnipeg because I live outside the city. And this is right in the inner city, so it's finding the place, and then not knowing anybody, not knowing who the HSMM dietitian* [Beth] *was. But upon arriving, they do a really good job of making you feel welcome and getting you right into things and explaining things. Beth must have explained it*

> *very well, because I found it very easy to fall into the role, and even that first day, I remember, once I got into it, not being nervous at all and enjoying it.*

As discussed above, the students' primary responsibility was the preparation of the snack served at the drop-in session. In response to a question asking Dorothy if she had actually observed a drop-in session, she replied:

> *If I have a few minutes, and I've got soup simmering on the stove, and I know that I've got ten or fifteen minutes with nothing to do, I can go upstairs and see what's going on with the program. And, I've also done some group activities with Beth* [HSMM dietitian].

In the first quotation below, Dorothy indicated that the students' volunteer experiences partly depended on the drop-in site, their expectations, and on the student taking the initiative to expand her role, as appropriate. In the second quotation, she described her "enhanced" volunteer role, including attending de-briefing sessions with the HSMM team:

> *It* [taking on an expanded role] *was just something that I just chose to do. I know by talking to one of my peers who volunteered for a short time with Healthy Start, that was something that she never did. She kind of felt she wasn't expected to do it, and she didn't feel a desire to do it. So, I think that's an individual choice. She didn't have a very good experience. If you were to speak to her and you've spoken to me . . . two completely different experiences. I think her expectations were more--maybe she wanted to see more of the role of a dietitian in a community program? And she didn't get to do that because she was in the kitchen. I think that if she had taken the initiative on her own it would have worked out differently. For myself, by doing that, I've seen a lot more of what the community dietitian's role is in the program.*
>
> *I'm involved in their de-briefing. Every time. I was invited to stay for the de-brief session once, and then they just kept asking me if I was going to sit-in. So, I just started going on a regular basis. A lot of the time I'm listening. Initially, I can remember they would often ask for my observations on what I saw, kind of as an 'outsider.' I wouldn't always be there for the whole time; I would be popping in and out of the drop-in session. The team members would ask; 'Did I think the drop-in was going smoothly? Did it look chaotic?' They always ask me how snack went and I can often help with that because I do clean-up. I can see how much food waste came back, or I can tell if the moms were coming back for seconds.*

Louise stated that, on occasion, she stepped out of her staff role and into the role of the food preparation volunteer, often when students were ill or unavailable on short notice. She described it as a *"nerve-wracking"* experience:

> *You're at the drop-in with so many moms, and babies, and dietitians meeting people, and nurses talking, and you're preparing this food. You're worried; 'What if I burn it?" Am I doing it right? Can I ask someone? How do you expect me to chop the cantaloupe?' If you're preparing a snack for the children, you're not always sure how to prepare it, especially if you don't have kids. For example, what are 'bite size' pieces? It can be a very intimidating and daunting experience. Because, you feel that you should know this, but you're just not sure.*

Dorothy suggested that it would be worthwhile for program staff to spend some time "up front" clarifying role expectations with the student food preparation volunteers:

> *I think at the orientation it is important for staff to question the volunteer; 'What are you wanting to get out of your volunteer experience?' That provides the volunteer an opportunity to say, 'I want to be part of food prep., obviously, because that's what I'm doing, but I would also like to be able to participate every once in a while in a group activity, or to 'shadow' the dietitian for a day to see what their role is.' That way the team knows that the volunteer is hoping to get a little bit more out of it.*
>
> *If the students stick to the kitchen--prepare the food, serve the food, clean the dishes and leave--they probably don't get a really good sense of the program. Unless the kitchen is right beside the room where the moms are, so they can actually see what's going on from where they're cooking, or unless they have a lot of moms helping them in the kitchen. Otherwise, unless they take the initiative, they're not going to get as much out of it.*

The HSMM food preparation volunteers were asked to complete anonymous feedback forms at the conclusion of their placements. Of the six forms reviewed, one respondent rated the volunteer experience as "great"; four respondents rated it as "good"; and one respondent rated it as "okay." All six students stated that they would recommend HSMM as a good volunteer opportunity for other Foods and Nutrition students. After reviewing the forms, Dorothy's suggestion that the students' expectations be clarified in advance took on additional importance. Several of the students indicated that they were hoping to gain more than food preparation experience. In fact, learning more about the role of the community dietitian and the opportunity to "interact more with the moms" were deemed to be important. These specific suggestions were made to improve the volunteer experience:

- Including more work related to nutrition
- Observing the dietitian at work
- Helping more with food demonstrations
- Linking more to program planning/ideas
- Giving volunteers more duties aside from food prep--continue to involve the volunteers in events/learning sessions taking place outside of food prep.
- Being able to be involved with the moms and the topics covered at the drop-in session gives a broader learning experience (Healthy Start for Mom & Me, 2000, unpublished data).

At the conclusion of the interview, Dorothy suggested that her undergraduate program had not adequately prepared her for her volunteer work in a community setting. She identified gaps in her professional training that impacted her ability to perform, even in a volunteer capacity:

> *You get your broad base of nutrition courses, which are essential. Once you get into your later years when you want to try and streamline more to your interests, there is not a lot of community-based courses offered. It's more your therapeutic--your clinical aspects of dietetics that are stressed more than community.*

Throughout the interview, it was apparent that Dorothy was missing important information related to the theoretical underpinnings of the HSMM program. When she returned her transcript of the interview, along with the signed release form, she added two hand-written suggestions:

> *I think it's important to share with the food prep. volunteers all the information that the program is based on so they gain an appreciation and an understanding of how they contribute. I had never heard of the 'Kitchen Table' Approach or 'Keep Nutrition in Your Back Pocket' or even the Collaborative Model. I think that these are important things that should be included into the orientation package and discussed with volunteers when they start.*
>
> *Also, I think by a student standing on the sidelines (preparing food) and watching a community dietitian, that can only give you so much knowledge about what they do. By 'jumping in' and 'playing' the role they can gain more of an understanding and an appreciation. Maybe this is one way to incorporate community nutrition into the university experience? Maybe it has to be taught outside the formal classroom?*

Dorothy's second suggestion raises an intriguing idea of formally integrating the students' volunteer experience at HSMM with the classroom learning acquired at the university. Informal conversations with other food preparation volunteers at the drop-in sessions, confirmed that their work with HSMM was not discussed in their community nutrition courses. Further, student volunteers with HSMM did not have a forum to get together to discuss their experiences, share lessons learned, or offer each other support. Thus, the students' volunteer work with HSMM was totally separate from their university experience.

Caraher (1994) observed that health promotion ideology, focused on the individual, is reinforced when undergraduate curricula distinguishes between the theoretical underpinnings of health promotion and the skills required to put theory into practice. When students are provided with opportunities to learn about health promotion concepts (e.g., empowerment and social support) and "identify and practice application within the same session," theory and practice become integrated and more meaningful (Benson & Latter, 1998, p. 104). Dietetic educators must ensure that students' practicum and/or volunteer experiences "bridge health promotion from individual and societal perspectives" (Rush, 1997, p. 1297). Findings indicated that Foods and Nutrition student volunteers in HSMM require familiarity with theories and methods of social as well as individual change.

When asked if she would recommend the experience of a HSMM food preparation volunteer to another student, Dorothy replied:

> *If they had any interest in community work, or if they were interested in pregnancy or infant nutrition, I would say; 'Go for it, because it's a great experience! You'll gain a lot from it. As long as you put the effort in, you're going to get a lot back. It's very rewarding. If you consider everything as a learning experience it will help you to keep an open mind and allow you to be receptive to all the valuable information that you hear.'*

Nora, like Dorothy, was a relatively recent graduate of a 4-year Foods and Nutrition program. She was critical of the undergraduate training that she had received and suggested the types of courses that would have assisted her in preparing for the role of a community dietitian:

> *Courses that would show you how to work with people. I took a communication course and when I look back, it's just lame and not at all useful. Nowhere do they teach you how to deal with people who are, say, lower income, or of a different culture. How to be nonjudgmental; how to treat people in a certain way; how to empower them. . . . We don't have courses like that.*
>
> *I did take the community nutrition class and it was interesting. They brought in different people that worked in the area so that's good--getting an*

> *understanding of that. I think other community placements, or spending time with community dietitians, would be good so you can see exactly what happens. Theory is only good for so much.*
>
> *I had no courses in prenatal nutrition; no courses in infant feeding; and no courses in nutrition over the lifecycle. I went into this type of work absolutely cold. So, of course, that made me very nervous. I was always looking stuff up and reading up on things. I tend do much better with topics that I can easily relate to--things like weight loss, label-reading, and general nutrition topics. Stuff related to babies is challenging, because I don't have a baby, and I don't have nieces and nephews. So, it was definitely a struggle for me to work in these areas and it still is.*

In response to a question asking if her dietetic internship, specifically the hospital-based pediatric rotation, was helpful in preparing her for her role as a community dietitian, Nora replied that

> *It's just clinical. The dietitian really doesn't spend much time with you and it's all about getting the infant formula right. A baby's on a special formula and you have to figure out this, and that, and you're focusing so hard on this mathematical equation. To this day I don't know what it is was. So, it was useless to me. And all the charting . . . everything was just so clinical.*

In summary, dietetic educators at the undergraduate and postgraduate levels must create an educational culture that is consistent with the philosophical and conceptual underpinnings of a population health approach (Benson & Latter, 1998). Rush (1997) recommended that educators critically evaluate the vehicles through which health promotion is delivered in university curricula "including models, texts, course content, and practicum placements" and expose the underlying ideology (p. 1297). Dietetic educators have a responsibility to ensure that health promotion theoretical constructs are made explicit in both clinical and community nutrition courses. Further, experiential activities at the undergraduate and post-graduate dietetic internship levels must integrate health promotion theory and practice in order to move dietetic education "upstream."

10.8. Section 2–Theoretical Constructs

10.8.1. Moving Dietetic Practice Upstream

Despite acknowledgement that an understanding of population health is essential to dietetic practice (Joint Steering Committee Responsible for Development of a National Nutrition Plan for Canada, 1996, p. 20), professional journals predominately feature research articles describing one-to-one relationships involving dietitians and their clients. These articles tend to emphasize the evolution of the relationship between dietitians and their clients with little attention to the forces in the broader social environment that are the source of many nutritional inequities and concerns (Kent, 1988). The examination of nutrition problems from a "small picture" perspective fosters inadequate consideration of the root causes of food insecurity. Further, it results in a restricted range of potential interventions for dietitians and distorts their impressions of clients' food-related behaviours.

"Upstream" endeavours are premised on the belief that the earlier in the "casual stream" one can act, the greater the benefits for health status (Health Canada, 1998b, p. 11). Dietetic practice, however, continues to emphasize downstream approaches, or microscopic perspectives, that fail to address the real causes of nutrition problems or concerns. Given this fact, it is timely for nutrition practitioners to ask: How does the profession's theoretical focus on the individual preclude understanding of a larger perspective? Travers (1997a) addressed the question when she stated that

> As long as nutrition educators place primary emphasis on changing individuals without consideration of their social context, the potential exists for victim blaming. Dogmatic nutrition messages do not assist the disadvantaged in making reasonable choices, and foster a sense of inadequacy and guilt among those who fail to live up to the standard. (p. 59)

Travers (1997a) concluded that because the social world is the source of many nutrition problems, critical social science may offer practitioners "the most appropriate theoretical perspective for nutrition education and research. (p. 61).

10.8.2. Understanding Critical Theory

Just as a population health approach recognizes the significance of the broad socio-environmental environment on health, critical social theory uses societal awareness as an aid to understanding health behaviours. This theoretical approach seeks to expose social inequities that prohibit people from reaching their full potential. A critical approach is based on the belief that life is structured by social meanings that are determined rather one-sidedly through social domination and/or oppressive power relations. Critical social theory assumes that standards of truth are socially determined and that no form of scientific inquiry is value free (Stevens & Hall, 1992). Proponents of this approach posit that "people develop systemic misunderstandings of themselves through their participation in a world in which public ideas and images distort reality in the interests of various dominant groups" (Travers, 1997a, p. 59). This notion has been called ideological false consciousness. Critical social theorists maintain that social discourse, free from power imbalances, will allow people to voice their beliefs without fear of authority or retribution. This, in turn, will stimulate the evolution of a more rational society.

Within the profession of dietetics, Travers (1997a) argued that research from a critical perspective could help to inform an empowering nutrition education practice. In her view, "an emancipatory nutrition education practice that explores the social roots to nutrition problems and works to address such issues as social isolation, low literacy skills, and poverty can **recreate** and **transform** the social world toward problem solution" (p. 59).

Community dietitians are well situated to acknowledge and challenge the nutritional inequities that people experience because of gender, socio-economic status, race, ethnicity, country of origin, and age. If dietitians are to apply critical theories to practice, they must explore the political aspects of oppressive health-damaging conditions by "taking a stand, asking tough questions, listening to the communities that they serve, forming coalitions, and acting collectively" (Stevens & Hall, 1992, p. 5). Additionally, dietitians must acknowledge that their success in the community depends on (a) a willingness to recognize the impact of the socio-economic environment on nutritional health; and (b) collective action at the community level to make the structural changes necessary to tackle the root causes of food insecurity.

10.8.3. The Need for Alternative Perspectives

The inherent danger of the traditional dietetic perspective lies not within its content but rather in the omission of other theories that enable dietitians to view situations from both a "small picture" and "big picture" perspective. Abrams et al. (1997) maintained that both individual and population-based approaches are necessary and complimentary to a comprehensive understanding of health promotion. Dietetics needs conceptual foundations that enable practitioners to understand health problems manifested at many levels: international, national and community, as well as those at the individual and family levels. The continued bias in favor of individual-level change theories deprives dietitians of an understanding of the complexity of the social world and an appreciation of the forces that shape nutrition-related behaviours at a population-level. A paucity of nutrition research focusing on the social context of health leaves dietitians with a limited understanding of their responsibilities to facilitate change at this level and without the tools or resources to promote change in an effective and systemic manner. Consequently, dietitians' efforts continue to focus on changing the behaviour of the individual client and/or modifying the client's perceptions of the world.

10.9. Summary

This chapter focused on the evolving role of the community dietitian in HSMM. Research findings highlighted the overlapping areas of community-based nutrition practice and the resultant role-confusion among community dietitians, other members of the interdisciplinary team, and the public. The findings reinforced the need to further define the scope of practice and underscored the importance of developing relevant community-based dietetic education curricula at the undergraduate and postgraduate levels.

Document reviews indicated a diversity of opinion on the roles and responsibilities of the community dietitian in CPNP. One perspective which emerged advocated a very traditional model of community nutrition interventions where the dietitian-expert acts as a change agent, trying to help marginalized individuals cope with the pressing food and nutrition issues that dominate their day-to-day lives. In this model, the major determinants of nutritional health well-being, and food security, are not considered. This perspective is consistent with traditional nursing practice described by Drevdahl (1995): "Nursing, for the most part, has aligned itself with the dominant culture, repairing damaged seams in the social fabric rather than looking for the structural and foundational changes needed to effect change for oppressed groups" (p. 21).

In sharp contrast, a second perspective which emerged called for a community development approach where dietitians, working in a team environment, use health promotion strategies to enable people to take more control over and thereby improve their health. In this model, the dietitian's role changes from expert to facilitator to advocate. These types of interventions provide an opportunity to address the broader socio-economic and political determinants of health and in the process lead to individual self-competence and community autonomy.

The research findings based on the experiences of program staff, community partners, and key informants in HSMM, described a re-orientation of nutrition services from hospital-based to community-based, and from the dominant individual orientation to a more social orientation. Because the issue of Gestational Diabetes Mellitus surfaced so frequently in the interviews, it was discussed in this chapter as a "case in point." Present and potential community dietitian roles and interventions specific to GDM were identified using an Integrated Model of Community Health Promotion (Laffrey and Kulbok, 1999). Findings confirmed that HSMM dietitians' efforts in the area of GDM were focused on three types of care (i.e., illness care, disease prevention, and health promotion) targeting four different client groups (i.e., individual, family, aggregate and community). However, the dietitians' work in the area of broad-based health promotion was seriously curtailed by the lack of community-based positions in Winnipeg and the time constraints of dietitians donating their services to HSMM on a bi-weekly basis. Additionally, the presence of the dietitian in the inner-city community was new so the dietitians' knowledge, skills, and capacities for community organization had yet to be developed.

Generally, interviewees emphasized that the transition to community-based practice required new attitudes, orientations, and approaches to practice. They called for the development of innovative models that address the "art" of nutrition practice, as well as the "science." Interviewees maintained that a solid foundation of effective cross-cultural communication techniques was necessary for community-based practice. HSMM dietitians stated that a broad understanding of the context of poverty and the systemic forces that influence access to the prerequisites of health was instrumental to their roles. Further, interviewees suggested that it was important for them to critically evaluate their own attitudes towards persons with low income, particularly in relationship to beliefs about the causes of poverty.

Research findings related to the role of HSMM's food preparation volunteers highlighted the importance of their contribution to the program. However, questions were raised through direct observation, and confirmed by interviewees, pertaining to the status of the student volunteers on the HSMM team. The interviewees emphasized that the use of the volunteers enabled the dietitian, and other team members, to be released from time-consuming food preparation activities at the drop-in sessions. Given the critical nature of their role, it was puzzling that the student volunteers were not represented on the HSMM Collaborative Outreach Model (Appendix C). Overall, the students' experiences in the HSMM program were positive, but findings suggested that the program staff could work more closely with the students to ensure that all needs were met. Further, the findings highlighted the importance of integrating the students' volunteer experiences with their university training to ensure that the theoretical underpinnings pertaining to population health promotion were in place. Additionally, interviewees suggested that an ongoing networking forum would assist the students with executing their tasks at the drop-in sessions and would offer mutual support.

The research findings also showed how community dietitians were creatively using "food to get to nutrition," apparently with great success. In the process, dietitians were developing a closer relationship with food, as they appreciated its power in mobilizing communities around common issues and concerns. HSMM dietitians raised thought-provoking questions pertaining to the risks and benefits of relinquishing some of their "expert role" in nutrition in order to establish informal, interactive, and "food-focused" approaches to group education. One of the perceived risks related to the perception that community dietitians were ranked lower on the dietetics hierarchy, and that their community-based role was considered inferior to the traditional role associated with hospital-based dietetic practice. A possible explanation related to the professional socialization of dietitians to value the scientific/technical approach to clinical practice over the practical/interpretive approach to community-based practice.

Finally, the research confirmed that the scope of community-based dietetic practice was very broad and that it was unrealistic to think that a single dietitian could attend to all levels of clients and all types of care identified in the Integrated Model for Health Promotion (Figure 2.2). Findings presented in Chapter 10 support Laffrey and Craig's (2000) conclusion that

> Community health nurses [and dietitians] must possess skills in communication, delegation, collaboration, and multidisciplinary work; place greater emphasis on identifying aggregates and communities at-risk for health problems; and assist them to develop services that alleviate the risks and enhance overall health. (p. 123)

Dietitians have an important role to play in working with nurses, and other community-based practitioners, to promote a common goal of a healthy community in a healthy society. While the role of the community dietitian in HSMM is just beginning to emerge, the research suggests that it holds much promise for the future.

CHAPTER 11

CONCLUSIONS AND RECOMMENDATIONS

11.1. Introduction

This chapter begins with an overview of the study, the methods used to gather research data, major findings, and the major themes which arose from the findings. The thematic discussions do not repeat in detail the findings contained in Chapters 4 to 10. However, the themes represent the researcher's interpretation of the functioning of HSMM based on a total of 21 individual interviews with program staff, community partners, and key informants. The themes also reflect data gleaned through two focus group interviews conducted with participant women. Direct observation and the review of program documents and archival information generated additional data on HSMM.

The research findings increased understandings of health promotion practices in disadvantaged communities and proposed an alternative orientation based on education, community participation, and capacity building. Additionally, the research added to knowledge of interdisciplinary collaboration as a key strategy in establishing the horizontal and vertical linkages necessary to promote population health. Further, the rich, qualitative data on HSMM contributed depth, detail, and meaning to the statistical findings and survey generalizations that Health Canada employed to track the general health of pregnant women/teens participating in Canada Prenatal Nutrition Program (CPNP) initiatives across the country.

Recommendations for practice and for further research are presented in Chapter 11 in relation to the literature in the areas of health promotion, population health, and prenatal nutrition. The chapter concludes with brief personal reflections on the experience of conducting the case study research on HSMM.

11.2. Overview of the Study

Traditionally, prenatal health promotion programs have used a combination of medical and behavioural approaches where risk factors have been modified through health education and lifestyle counseling. Recently, in large part because of research on the non-biological determinants of health, and on health promotion, the focus has shifted to the societal level. Increasingly practitioners recognize that factors in the social world are rarely within the direct control of individuals, professionals, and communities. The theoretical justification for a socio-environmental approach to prenatal health promotion provided the rationale for the case study research on Healthy Start for Mom & Me (HSMM).

This qualitative case study examined HSMM--a collaborative, multi-faceted prenatal nutrition program in Winnipeg, MB. HSMM was funded by Health Canada's Canada Prenatal Nutrition Program (CPNP) and the Manitoba Department of Family Services (WIN Program). The sponsor of HSMM was Dietitians of Canada, a professional association of approximately 5000 dietitians employed in a wide variety of practice settings. The purpose of the study was to describe the dynamics of HSMM operations; to understand the experiences of participant women, staff, and community partners; and to interpret how the program "worked" within a socio-environmental context.

There were three major research questions. First, what were the salient themes, patterns, and categories in the meaning structures of participants, staff, and community partners? Second, how were these themes, patterns, and categories linked with one another? Third, how did these themes, patterns, and categories operate within a socio-environmental context? These questions, drawn from the theoretical framework, guided data collection and analysis. In addition to the three major research questions, the researcher developed 10 specific research questions to guide the study. These questions are discussed in Section 11.3.

HSMM is a city-wide program, operating from eight community-based sites. An in-depth examination of the day-to-day operations of the eight sites would have generated more information than was manageable given the scope of a PhD thesis. Several desirable sites had to be omitted by the bounding process (Stake, 1995). The study focused on two well-established sites within HSMM. The demographics of the participants attending both sites were relatively similar with one exception. There were more immigrant/refugee women attending the Willow Community Centre site in comparison to the Evergreen Community Centre site. Many of the immigrant/refugee women lived in a short-term, low-income housing complex located close to the Willow Community Centre site. Translation services were provided on a regular basis at the HSMM drop-in sessions at the Willow Community Centre site. They were also required during the focus group interview with participant women held at that site.

The nature of the communities surrounding the two HSMM sites--including racial, ethnic, and economic mix--were not remarkably diverse. Staffing configurations differed between the sites with one site (Evergreen Community Centre) relying on HSMM for dietitian and peer outreach services and support, and the other site (Willow Community Centre) relying on a community partner (Inner-city Health Centre) for dietitian services only. Drop-in sessions at both HSMM sites were co-facilitated by community/public health nurses employed by the Winnipeg Community & Long Term Care Authority (WCA).

Data collection drew extensively on multiple sources of information, as recommended by Stake, 1995. The research design included participant observation at the drop-in sessions (total observation time: 24 hours); individual interviews with program staff and key informants (n=21); two focus group interviews with participant women (n=23); as well as a comprehensive review of documents and physical artifacts. Multiple data collection methods served as an internal validity/credibility check (triangulation), so that data obtained by one method could be checked against data obtained by another method (Miles & Huberman, 1999). Semi-structured interviews and open-ended questions were used to provide maximum opportunities for interviewer and interviewee to explore meaningful topics of interest to both without the restrictions of preset questions associated with structured interviews. A trained facilitator conducted the two focus group interviews to elicit participants' perceptions of their experiences in HSMM without imposing any of the researcher's views. Participant women self-selected for the focus group interviews: 12 at the Evergreen Community Centre site and 11 at the Willow

Community Centre site. While all focus group participants were "enrolled" in HSMM, there were considerable differences among participants with respect to age, race, cultural background, and length of exposure to the program.

Data generated throughout this research project were analyzed using perspectives from ethnography and narrative inquiry (Denzin, 1997). The use of narrative concerns the construction of knowledge from personal experiences. This study also sought to give "voice" to the perceptions, experiences, and insights of participant women, program staff, and community partners in HSMM. This was accomplished through the analysis of narrative accounts illuminating what it meant for participants and team members to be part of HSMM (Clandinin & Connelly, 1990; Poklinghorne, 1995). Further, grounded theory techniques helped the researcher interpret the data rigourously and in sequence. Analysis was made less onerous by the use of computer-aided qualitative data analysis, an approach advocated by Kelle (1995).

Ethical concerns in this research project involved participants' privacy, consent, respect, and safety (Glesne & Peshkin, 1992). Ethical approval was received from the University of Alberta's Faculty of Agriculture, Forestry, and Home Economics Review Committee and the Winnipeg Community & Long Term Care Authority (WCA) Research Review Committee. This study met the University of Alberta's research guidelines by ensuring that participation in the case study research was voluntary, that participants clearly understood that they could withdraw at any point in the study, and that participants had the right to privacy and confidentiality. In reporting the findings of the study, pseudonyms were used to represent the HSMM sites, partner agencies and organizations, and the research participants.

Permission to conduct the study was sought from the HSMM Steering Committee and the sponsor of the program--Dietitians of Canada. Relevant procedures to ensure trustworthiness were employed. Member checks (Miles & Huberman, 1994) were conducted to ensure that participants had final approval over research data collected, and that they had the opportunity to withdraw from the research project at any time. Trustworthiness was ensured by asking respondents to review transcripts of interviews; by declaring personal biases and practicing reflexivity; by using a variety of methods for data collection; and by establishing audit trails.

11.3. Major Findings

Findings pertaining to the 10 specific research questions are not limited to any one chapter of the thesis. The broad scope of the questions, the overlapping nature of some of the questions, and the inter-connectedness of the questions to various elements of the case study research on HSMM resulted in information relevant to each specific research question being embedded in various Findings chapters.

Specific Research Question 1: "How were participant women brought into HSMM and how did they move through the program once they become participants?"

The findings are presented primarily in Chapters 4 and 5. They confirmed that the majority of participant women/teens self-referred to HSMM having heard about the program through family members and friends. Outreach services were critical in increasing community awareness of HSMM, enhancing social support, and bolstering the self-confidence of participant women. The other "hooks" associated with HSMM's "Kitchen Table" approach (Figure 11.1) served to decrease socio-economic and geographical barriers to women's participation in the program.

Specific Research Question 2: "What were the factors that influenced community partners' decisions to participate in the program?"

The findings are discussed in Chapters 7 and 8. Community partners acknowledged that past programming efforts specifically targeting the HSMM population had met with limited success. HSMM represented an innovative approach to community organizing where agencies/organizations worked with participant women/teens to identify and take action on priority issues and concerns. In this regard, HSMM functioned as a kind of glue, that maintained the interest of both participant women and community partners, nourished active involvement in the program, and encouraged the ongoing support necessary for program sustainability.

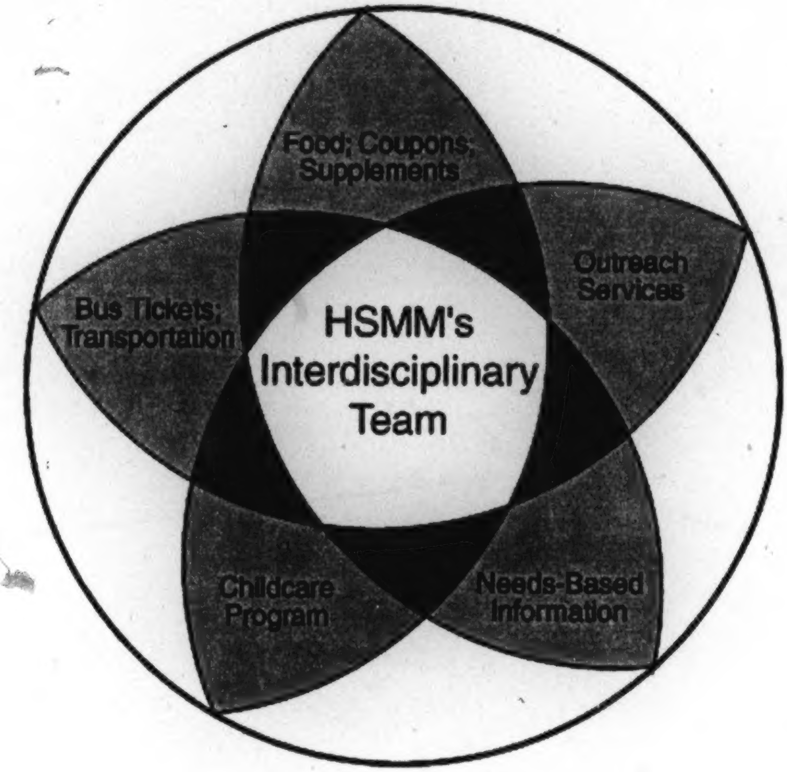

Food; Coupons; Supplements
Outreach Services
Needs-Based Information
Childcare Program
Bus Tickets; Transportation
HSMM's Interdisciplinary Team

Figure 11.1. HSMM's "Kitchen Table" approach.

Specific Research Question 3: "What were the experiences of participant women, program staff, and key representatives of the broader community in HSMM?"

The scope of Specific Research Question 3 is very broad. Hence, the findings pertaining to Question 3 are found in Chapters 4 to10. The content embedded in the seven Findings chapters describes a process of community organization that facilitated empowerment at four levels--individual, small group, local community, and the larger community represented by a broad-based coalition of partner agencies and organizations. HSMM fostered intersectoral action and local empowerment through the mobilization of community interest, talent, and resources. Further, skilled community organizers connected diverse networks of government, community agencies/organizations, and voluntary groups to plan, implement, and consolidate HSMM between 1995 and 2000.

Specific Research Question 4: "What was the nature of the interactions between participant women, program staff, and staff contributed from partner agencies and organizations?"

Findings presented primarily in Chapter 5 address Specific Research Question 4 through the experiences of participant women in HSMM. The findings indicated that participants perceived HSMM team members as the "heart" of the program, offering both information and support in a warm, friendly, and nonjudgmental manner. Question 4 is also addressed in Chapters 4, 6, 9, and 10 through the experiences of program staff, community partners, and key informants. When discussing interactions between team members and participant women, interviewees consistently described the role of the peer outreach worker in providing a critical bridge in reducing the gap between HSMM participant women/teens and professional staff.

Specific Research Question 5: "How had the lives of participant women changed over the course of their involvement in HSMM?"

The findings discussed in Chapter 5 showed that participants' experiences of pregnancy were inextricably linked with the social context and stresses of their lives. When describing their experiences in HSMM, participant women highlighted the knowledge gained in a variety of areas (e.g., normal fetal development; breast feeding; basic food preparation); demonstrated support from peers and program staff; and the increased self-confidence and capacity-building that resulted from their participation in the small group process. They also confirmed the importance of the tangible and practical program resources including milk coupons, bus tickets, and on-site childcare to their participation in the program.

Specific Research Question 6: "What differences had the program made in the inner-city communities that it serves?"

The Empowerment Holosphere in HSMM (Figure 11.2) was used as an organizing framework for the case study research. Research findings, embedded in Chapters 4 to 10, confirmed that HSMM increased intersectoral action and local empowerment on four levels. First, interventions targeted the individual participants and, on occasion, their families (i.e. sphere 1--personal care). Second, the bi-weekly drop-in sessions facilitated empowerment at the "level" of the small group (i.e., sphere 2--small group development) primarily through the actions of the peer outreach workers. Third, the community organizing process enabled HSMM to offer a menu of prenatal services to high-risk women/teens beyond the scope and/or mandate of any one individual agency or organization (i.e., sphere 3--community organization). Fourth, as HSMM consolidated, its "reach" in the Winnipeg community was extended to include interventions represented in sphere 4--coalition building and advocacy. Findings reported in Chapter 8 suggested that HSMM had yet to establish a strong presence in sphere 5--political action.

Data presented in Chapter 9 and 10 indicated that the practices of HSMM's interdisciplinary teams enhanced intersectoral action by establishing the horizontal and vertical linkages necessary to promote population health. Team members utilized a wide range of health promotion strategies including empowerment education approaches represented in spheres 1 through 5 of The Empowerment Holosphere in HSMM (Figure 11.2).

Specific Research Question 7: "What were the strengths and weaknesses of the program?"

Findings relevant to this very broad question are addressed in Chapters 4 to 10. In Chapter 5, findings indicated that it was difficult for participant women to articulate the weaknesses of HSMM, however, they did offer several concrete suggestions for improvement of the program. These included the development of an on-site resource centre where women could borrow prenatal and/or parenting resources of interest. Further, participant women emphasized the importance of continuing the distribution of milk coupons during the postnatal period.

In Chapters 6, 9, and 10, program staff, community partners, and key informants discussed the strengths of HSMM at length. A key strength pertained to the effectiveness of the "Kitchen Table" approach (Figure 11.1) in attracting and retaining participant women in the program. In discussing the weaknesses of HSMM, team members and key informants voiced shared concerns pertaining to the ongoing challenges associated with program evaluation, time constraints, human resource issues including a shortage of community dietitians, and the initial lack of understanding and support in some sectors related to the implementation of new collaborative approaches to delivering community-based services.

Specific Research Question 8: "How had active involvement in the program changed stakeholders' understandings of prenatal health promotion?"

Relevant findings are presented in Chapters 6, 8, 9, and 10 based on the experiences of program staff, community partners, and key informants. They indicated that professional team members had gained a deep appreciation and respect for the role of the peer outreach worker in HSMM. Furthermore, although team members were aware of the lack of social support networks in inner-city neighbourhoods, they appeared to be surprised and humbled by the magnitude of social isolation in the lives of participant women. Also, findings suggested that program staff and community partners were overwhelmed by the power of HSMM's "Kitchen Table" approach to mobilize a previously un-reached population to take action on priority health and social issues.

Specific Research Question 9: " What issues and tensions had emerged from the program's emphasis on interdisciplinary teams, including the peer outreach workers' practices with marginalized women and their families?"

Research findings described primarily in Chapters 6, 9, and 10 deal with Specific Research Question 9. An important finding related to the significance of the formal training and orientation that the three peer outreach workers received prior to beginning work with HSMM. In HSMM, the peer outreach staff were involved in a broad range of activities with participant women including advocacy necessary for policy and practice change at the provider and institutional levels. Research findings pertaining to the role of the community dietitian in HSMM highlighted the overlapping areas of community-based nutrition practice. Additionally, the confusion in terminology relating to the use of "nutritionist" versus "dietitian" was raised by peer staff, community nurses, and participant women. The role of the dietitian in HSMM was emerging, and standards of community-based dietetic practice were not clear to interdisciplinary team members.

Specific Research Question 10: "How had interdisciplinarity challenged the norms and values of the practitioners' professions?"

Findings relevant to this question are presented in Chapters 6, 9, and 10. A central observation related to the tendency of health professionals to strive for expert knowledge and skill development, largely as a result of their pre-professional training. This emphasis on specialization was sometimes in conflict with the roles and responsibilities necessitated by an integrated model of service delivery. Community dietitians emphasized that the transition to community-based practice required new attitudes, orientations, and approaches to practice. They called for the development of innovative models that speak to the "art" of nutrition practice, as well as to its "science."

11.4. The Empowerment Holosphere in HSMM

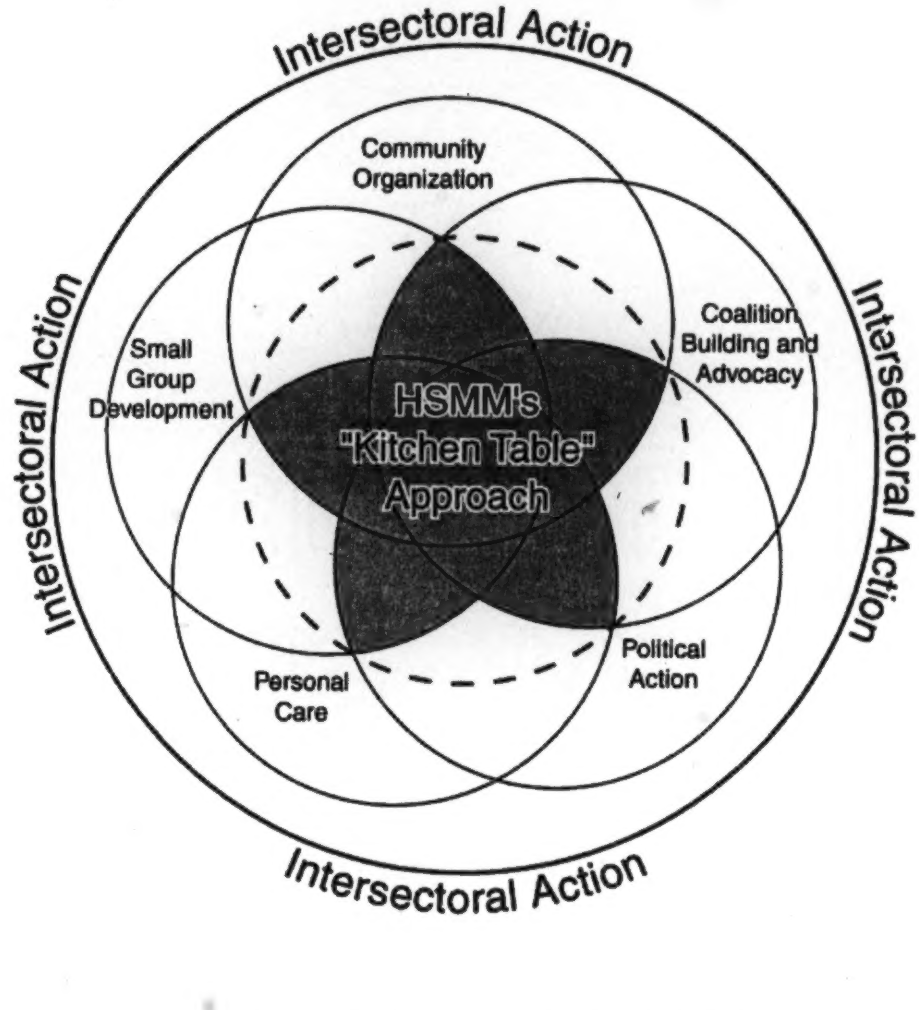

Intersectoral Action
Community Organization
Coalition Building and Advocacy
Political Action
Personal Care
Small Group Development
HSMM's "Kitchen Table" Approach
Intersectoral Action
Intersectoral Action
Intersectoral Action

Figure 11.2. The Empowerment Holosphere in HSMM.

The Empowerment Holosphere in HSMM (Figure 11.2) is a health promotion practice model that identifies the range of strategies that HSMM participant women, program staff, and community partners employed in a collaborative effort to reduce or ameliorate inequitable social conditions. The holographic design is adapted from Labonte's Empowerment Holosphere (1994). Heuristically, the holographic model depicted in Figure 11.2 links in practice the multiple levels of empowerment--individual, organizational, and community--described by Israel et al. in 1994. It is important to acknowledge that the individual health worker, or discipline, cannot assume responsibility for enacting the full range of strategies depicted in the model.

The Empowerment Holosphere in HSMM (Figure 11.2) provides an organizing framework for the major findings emerging from the case study research. According to the model, HSMM can be conceived of as a series of overlapping spheres or "levels" of empowerment. The model serves to highlight relationships between the spheres that influence the functioning of HSMM. At a practice level, The Empowerment Holosphere in HSMM (Figure 11.2) incorporates a number of key ideas that further develops and synthesizes knowledge in the area of empowerment education.

First, the model emphasizes the contextual environment in which health promotion programs operate. In the design and implementation of HSMM, considerable attention was paid to the broad socio-economic environment and its relationship to the health and social issues/concerns of participant women. Second, the model describes a health promotion program in terms of interrelated spheres or systems. HSMM included individuals who were part of groups or departments that belonged to larger organizational systems. Third, the model establishes "alignments" or linkages between the overlapping spheres or systems. McLeroy et al. (1988) referred to intra- and interorganizational relations, using configurations of subsystems to depict key patterns of interconnectedness.

Labonte (1994) maintained that interventions targeting all five spheres were necessary to reach the "level" of political action required to achieve social change. Collectively, these ideas point the way to new theories that allow practitioners to move away from bureaucratic, "stove pipe" approaches to health planning. The holographic design (Figure 11.2), based on case study research findings, proposes an alternative orientation to health promotion practice that enables practitioners, participant women, and the community to organize in a way that addresses the broader socio-economic and political environment.

In summary, within HSMM, the five overlapping "levels" of empowerment education have an overlapping and circular quality. They are all inter-connected and blend with each other. The Empowerment Holosphere in HSMM (Figure 11.2) does not serve as a blueprint or a recipe for success to achieving social change. Rather, it represents an approach through which the reader can understand and reflect on the functioning of HSMM.

11.5 Major Themes

Seven major themes emerged from the case study research on HSMM. They include (a) HSMM's "Kitchen Table" approach, (b) the empowerment of participant women, (c) the bridging role of HSMM peer outreach workers, (d) community organization in HSMM, (e) coalition building and advocacy in HSMM, (f) interdisciplinary collaboration, and (g) the evolving role of the community dietitian in HSMM. Each of the major themes is summarized below.

11.5.1. HSMM's "Kitchen Table" Approach

HSMM's "Kitchen Table" approach (Figure 11.1) served as a springboard to improving participants' access to food, enhancing their cooking skills, increasing their self-confidence, and strengthening their social support networks. Further, the activities related to preparing food and eating together established common ground between program staff and participants. In Figure 11.2 (The Empowerment Holosphere in HSMM), the relative size and centrality of the "Kitchen Table" approach underscores its significance to all aspects of program operation. The model illustrated in Figure 11.2 suggests that the design and implementation of the "Kitchen Table" approach was the initial step in the empowerment education process. More specifically, before women and teens could become involved in the community organization process, they required knowledge, skills, and resources delivered through HSMM's "Kitchen Table" approach.

The "Kitchen Table" approach was responsible for attracting women to the drop-in sessions and sustaining their involvement in the program. In focus group interviews, participant women confirmed that the key features of the "Kitchen Table" approach (Figure 11.1) contributed to the overwhelming success of the program in attracting a previously un-reached population. The contextual influences that facilitated group discussion and participants' readiness-to-learn included an accessible non-threatening physical environment at the drop-in sessions; the provision of food and supplements, outreach services, needs-based information, free childcare on-site, bus tickets to and from the drop-in sessions; and, a relaxed informal approach to program delivery.

A traditional approach to education is based on the teacher "filling" students' heads "by making deposits of information which the teacher considers to constitute true knowledge" (Freire, 1971, p. 63). In contrast, an empowerment education approach, as advocated by Freire (1971), engages people through group discussion in identifying their own problems and in critically assessing the social, historical, and cultural roots of their problems. Empowerment education relies on "midwife-teachers"--the opposite of "banker teachers," described by Freire (1971). While the "banker teacher" deposits information in students' heads, the "mid-wife teacher" draws it out. (Belenky et al., 1986) In HSMM, interdisciplinary team members served as "mid-wife teachers." They assisted participant women in "giving birth to their own ideas, in making their own tacit knowledge explicit, and elaborating it" (Belenky et al. 1986, p. 217).

HSMM's "Kitchen Table" approach recognized the potential of food and nutrition as an entry-point to population health (Health Canada, 1998b). At the same time, the approach was realistic and sensitive to the everyday challenges faced by persons with low incomes. According to HSMM team members, the "Kitchen Table" approach represented a healthy start to improving the food security of high-risk pregnant women and their families. In summary, the research explicating HSMM's approach to working with marginalized women facilitates health promotion practices that are more sensitive to the needs of women/teens by assisting practitioners in understanding the context of HSMM participant's lives.

11.5.2. The Empowerment of Participant Women

The loci of direct service activities in HSMM included home visiting, nutrition counseling, and public health nursing. These services were extremely important in offering social support and self-care to participant women. When describing their experiences in HSMM, participant women highlighted the knowledge gained, demonstrated support from peers and program staff, and revealed increased self-confidence and capacity building that resulted from their participation in the group process.

The limitation of interventions directed at the "level" of personal care is that they fail to recognize the complexities of human behaviour. Further, they ignore the crucial connection between individual behaviour and the social world. Research findings confirmed that participants' experiences of pregnancy were inextricably linked with the social context and stresses of their lives. Poverty, social isolation, and a lack of resources were significant factors in participants' well-being. Women and teens described challenging life circumstances and daily struggles for survival. In many cases, pregnancy exacerbated the chronic stress, chaos, and crisis in their lives. In effect, participant women described the physical and social risk factors for powerlessness (Wallerstein, 1992).

HSMM team members established a role in providing services at the individual level that reduced the effects of poverty. Empowering services respected individual autonomy and personal choice, were culturally sensitive, reflected an understanding of the socio-environmental context of participants' lives, and worked to build the capacities of women to take action on the root causes of their distress (Reutter, 2000). The research further developed and synthesized knowledge pertaining to the role of peer outreach worker in bridging the gap between participant women and professional staff.

Health promotion theory defines the community "as the engine of health promotion, the vehicle of empowerment" (Labonte, 1994, p. 62). However, Labonte argued that a more accurate definition would suggest that the small group was in fact "that locus of change, that vehicle of emancipation" (p. 62). In HSMM, participants would have remained marginalized and uninvolved had programming efforts been targeted solely at the "level" of sphere 1--personal care. Through their ongoing involvement in the bi-weekly drop-in sessions, participant women gained the health-enhancing characteristics essential to empowerment: control, capacity, coherence, and connectedness (Wallerstein, 1992).

11.5.3. HSMM's Peer Outreach Workers: Bridging the Gap

Within HSMM, peer outreach workers played a pivotal role in facilitating the empowerment of the small group. This phenomenon is described in detail in Chapter 4 on the "Kitchen Table" approach. Specific activities at the drop-in sessions included transporting new participants to the site; facilitating the "ice-breaker" activity; distributing milk coupons; and leading the debriefing meetings with team members. Additionally, peer outreach workers maintained contact with participant women between the drop-in sessions on an as-needed basis. Research findings indicated that HSMM's peer support staff provided a trusted bridge between the intrapersonal and interpersonal aspects of social support (self-help, self-efficacy, and self-esteem) and the community social change potential of social support (organizing, advocacy, and healthy public policy) (Israel et al., 1994).

As the peer outreach workers' empowering practices with participant women developed, other personal and very poignant stories of empowerment emerged. The research findings described the peer outreach workers' individual journeys of empowerment between 1995-2000 as they made the transition from single mothers on social assistance to highly valued members of the HSMM team.

11.5.4. Community Organization in HSMM

The Empowerment Holosphere in HSMM (Figure 11.2) strategically posits sphere 3--community organization between the spheres of small group development and coalition building and advocacy. According to Labonte (1994), community organization is key to reaching the upper "levels" of the Holosphere necessary to achieve social change. Within the sphere of community organization, the research findings described how interdisciplinary team members and partners organized to take action on community-identified issues that were beyond the scope and/or mandate of any one organization or agency.

Chapter 7 describes the community organization process between 1995 and 1997 that resulted in the design and implementation of the HSMM's Collaborative Outreach Model (Appendix C). The first three phases of the community organization process involved specific strategies to accomplish the complex work. They included securing a sponsor, selecting a lead organizer, starting with the voices of participant women, collecting community data, encouraging shared values, choosing an organizational structure, defining program goals and objectives, identifying and recruiting partners, clarifying roles and responsibilities, and, recruiting talented staff and volunteers (Bracht, 1999; Labonte, 1993).

In summary, the case study research on the community organization process in HSMM revealed how an intersectoral approach was used successfully to address multi-faceted health and social issues at the community level. The findings contributed new knowledge pertaining to key facilitating factors and barriers for broad-based intersectoral action.

11.5.5 Coalition Building and Advocacy in HSMM

In The Empowerment Holosphere (Labonte, 1994), coalition building and advocacy are combined because successful advocacy efforts usually involve community-based coalitions. In practical terms, however, it was difficult to contain the discussion of advocacy in HSMM to this sphere. Findings suggested that advocacy was integral to the roles of the peer outreach worker and HSMM professional team members. Hence, the topic of advocacy in HSMM is raised in Chapters 7, 9, and 10. HSMM represented a new type of coalition highlighting the advocacy potential of professional volunteer associations, as opposed to the more traditional type of coalition sponsored by organizations that employ health professionals (Labonte, 1994). In agreeing to sponsor HSMM, Dietitians of Canada took a position on prenatal health promotion advocating more equitable, accessible, and sustainable forms of health/social programs and policies.

Research findings pertaining to coalition building in HSMM described ways to adapt or circumvent traditional professional or bureaucratic systems when necessary to meet the needs of women and the collective needs of the HSMM partnership. Team members moved outside their own professional settings to provide services in nontraditional settings using nontraditional approaches. Program staff and community partners spoke of redefining their roles to respond to the significant needs of the target population. Because HSMM represented a shared power structure, consensus building and negotiation were necessary around most decisions. Community partners were generally not accustomed to sharing power and responsibilities, thus, new norms and cultures in HSMM provided a context for working collectively.

To date, HSMM has not established a strong presence in the political arena. However, findings suggested that HSMM is well poised to take political action in the future.

11.5.6. Interdisciplinary Collaboration

The Action Statement for Health Promotion in Canada (Canadian Public Health Association, 1996) maintained that reform of health systems called for improving interdisciplinary health promotion practice and stronger alliances among those who are working in health promotion, population health, community social services, and primary health care. The authors suggested that stronger professional alliances would come from sharing different perspectives on how to promote health, encouraging interdisciplinary action on the determinants of health, and strengthening the collective voice for advocating healthy public policy (p. 7).

Stewart (2000, 1990a) argued that primary health care rests on more than professional collaboration. She emphasized the importance of partnerships with focal persons (i.e. clients or patients), social networks, and lay helpers or peer staff. Laypersons and health professionals have identified role ambiguity as a barrier to building relationships (Northouse & Northouse, 1998). Stewart (1990a) stated that role conflict and/or confusion between lay and professional staff must be prevented by the re-socialization of roles. Within HSMM, findings indicated that initially there was tension between public health nurses, community dietitians, and peer support staff largely the result of role ambiguity.

Following the implementation of HSMM, organizational changes were necessary to fully institutionalize the program in the Winnipeg community. Research findings supported the conclusions of McLeroy (1988) that it was critical to secure the buy-in of upper-level management within partner agencies. At an organizational level, requisites for interdisciplinary collaboration in HSMM included time, demonstrated managerial understanding and support, and the orientation and ongoing training of team members.

The case study research provided valuable insights into skills and theoretical knowledge that facilitate interdisciplinary collaboration between public health nurses, community dietitians/nutritionists, and peer outreach staff actively participating in a prenatal nutrition program. HSMM success rested on the ability of team members to coordinate and integrate specialized knowledge within a comprehensive health promotion program. The integration of diverse areas of expertise including nutrition and domestic violence reduced duplication and strengthened the provision of comprehensive services to participant women. The successful integration of roles and responsibilities depended on professionals having a thorough knowledge of their own discipline in order to see how it contributed to the whole. HSMM staff and community partners who felt confident, secure, and competent in their roles could best communicate their professional strengths, limitations, and "growing edges" to the other members of the team.

11.5.7. The Emerging Role of the Community Dietitian in HSMM

The case study research on HSMM described a re-orientation of nutrition services from hospital-based and from the dominant individual orientation to a more social orientation. Findings highlighted the need to further define scope of practice and underscored the importance of developing relevant community-based dietetic curricula at the undergraduate and postgraduate levels.

Documents reviews suggested that there was a diversity of opinion on the roles and responsibilities of the community dietitian in CPNP. One perspective (CPNP-Saskatchewan 1999, pp. 1-2) advocated a very traditional model to community nutrition interventions where the dietitian expert acts as a change agent trying to help marginalized individuals cope with the pressing fod and nutrition issues dominating their day-to-day lives. According to this view, the larger determinants of nutritional well-being are not considered.

In contrast, a second perspective (Ontario Dietetic Association, 1993, pp. 1-21) called for a community development approach where dietitians working in a team environment use health promotion strategies to enable people to take control and thereby improve their health. These types of interventions provide an opportunity to address the broader socio-economic and political determinants of health and in the process lead to individual self-competence and community autonomy.

The inherent danger of the traditional dietetic perspective lies not within its content but rather in the omission of other theories that enable dietitians to view situations from both a “small picture” and “big picture” perspective. Abrams et al. (1997) maintained that both individual and population-based approaches are necessary and complementary to a comprehensive understanding of health promotion. Research findings emphasized that dietetics needs conceptual foundations that enable practitioners to understand health problems manifested at many levels: international, national and community as well as those at individual and family levels. The continued bias in favor of individual-level change theories deprives dietitians of an understanding of the complexity of the social world and an appreciation of the forces that shape nutrition-related behaviours at a population-level. Further, a paucity of nutrition research focusing on the social context of health (Travers, 1997a, 1997b) leaves dietitians with a limited understanding of their responsibilities to facilitate change at this level and without the tools to promote change in an effective and systemic manner.

Research findings related to the role of HSMM’s food preparation volunteers (Foods & Nutrition students from the University of Manitoba) emphasized the significance of the volunteers to the program. The students released the dietitian and other team members from time-consuming food preparation activities at the drop-in session. Hence, staff had more time to spend with participant women. Given the critical nature of food preparation volunteers’ role to program functioning, it was puzzling that the students were not specifically represented on HSMM’s Collaborative Outreach Model (Appendix C). Findings indicated that it was necessary to integrate the students’ volunteer experiences with the undergraduate community nutrition curricula to ensure that the theoretical underpinnings pertaining to prenatal health promotion in disadvantaged communities were in place.

11.6. Recommendations for Practice

The following recommendations are offered for consideration by health promotion practitioners, dietitians/nutritionists, representatives of funding agencies, and dietetic educators. The recommendations are based on the case study research findings, the emergent themes, the researcher's observations, and the relevant literature. They are divided into four categories that reflect the findings discussed in Chapters 4 to 10. The recommendations pertain to (1) planning, implementing, and evaluating community-based programs (2) dietetic practice (3) program funding, and (4) dietetic education and training.

11.6.1. Recommendations on Planning, Implementing, and Evaluating Community-Based Programs

1. Before individuals and organizations can become involved in decision-making and action on community-identified health issues, they often need knowledge, skills, and practical resources. These participatory "hooks" must be built into the community organizing and community building process. Further, community development leadership and expertise should be contracted if it does not exist within the planning team.
2. Marginalized individuals will actively participate in the community organizing process when they feel welcome, see the issues as relevant and worthwhile, view the process as open and supportive, and are involved at all stages of program design, implementation, and evaluation. In determining the program setting, the participants' perceptions of their physical safety must be considered. The geographical accessibility of the setting, and the provision of a non-threatening environment, are important requisites.
3. Health behaviours are strongly influenced by culture. To ensure that community-based programs are culturally and linguistically appropriate, they must reflect knowledge and respect for the targeted population's culture. In this regard, peer support staff have proven success in bridging the gap between professional staff and program participants. Formal training, orientation, and ongoing support are

critical determinants of job performance and should be incorporated into program design and implementation.

4. Coalitions, when adequately supported, can be used effectively to marshal community interest, expertise, and resources for health decision-making and action. Stakeholders must first determine the type of partnership that will best meet community-identified needs (e.g., service integration effort, problem-solving collaboration, or a comprehensive multi-sectoral initiative). Given that the decision to join a coalition is strongly influenced by community members' beliefs that the benefits of participation outweigh the costs, community organizers should emphasize the value-added factors.
5. Interdisciplinary teamwork blurs professional boundaries. Individuals must acquire new skills and expertise to function effectively. Management support and understanding is critical. Team members' roles and responsibilities must be seen as legitimate. Realistic timelines should reflect the slow pace of community-based work.
6. Professional volunteer associations have demonstrated potential in leading and/or sponsoring coalition building and advocacy initiatives. Further, professional associations have well integrated communication networks nationally, provincially, and locally that can be used effectively to build a broad base of political support necessary to achieve social change.
7. Given that inspired and trusted leadership is the single most important factor in effective coalition building, succession planning is critical to ensure that there is continuity in programming should a vacancy occur.
8. Community organizers should formalize agreements among coalition partners to ensure that there is follow-through on actions. Written agreements are also effective in establishing a shared understanding of the goals, short- and long-term objectives, and the norms/values on which the coalition is based. Timing is an important consideration. While formal agreements should not be initiated too early in the coalition building process, at later stages the absence of formal agreements weakens and/or threatens the partnership by failing to secure stakeholders' commitments to follow-through.

9. Programming must encompass higher-level social actions necessary to improve prenatal and birth outcomes in marginalized populations. Interventions at this level include advocacy and political actions necessary to reduce income disparities; ensure a more equitable distribution of wealth; create employment and working conditions that promote maternal/child health; improve access and support for lifelong education and training; and employ tobacco, alcohol, and drug reduction strategies.
10. In evaluating community-based programs, practitioners should use multiple data collection methods: questionnaires, face-to-face interviews, telephone surveys, observational data, and the review of archival information as evaluation tools. Evaluators should seek convergence in data between community organization outcome indicators and individual-level indicators.

11.6.2. Recommendations on Dietetic Practice

1. Recognize the limitations of traditional approaches to dietetic practice that focus on individual behaviour change. The demonstrated influence of environmental and systemic factors on individual and community health call for innovative practice models concerned with community-level and systemic change.
2. Use community-based empowerment education approaches. Consider patients and/or clients as partners in the process of identifying and solving their own issues and/or concerns. These approaches offer new and efficacious models on which to base professional-client interactions. Further, they inspire confidence in the self-actualizing potential of participation.
3. Think "outside the box." Since effective advocacy efforts depend on successful partnerships with the community, allied health professionals, and non-health sectors, dietitians need to take a leadership role in building broad-based coalitions for nutritional health. Such coalitions will strengthen the political base of support for social change.
4. The social value of food--preparing meals and/or snacks and eating together--can serve as a powerful entry-point to population-health programming. The knowledge and capacities of dietitians to use food-focused approaches in

community-based practice should be enhanced through further exploration and reflection.

5. Dietetic leaders should communicate with colleagues in undergraduate dietetic education about the knowledge, skills, and competencies required for a population health approach. Preparation for practice must include specialized knowledge from fields and disciplines outside of dietetics (e.g., public health, environmental health, social psychology, political science, economics, and adult education).
6. Practising dietitians require enhanced knowledge, skills, and capacities pertaining to population health promotion. Strategies could include post-graduate distance education courses in public health/community nutrition and/or health promotion. Self-learning modules focusing on the determinants of health, intersectoral partnerships, and empowerment education approaches should be included in continuing education programs for community-based practitioners. Face-to-face networking opportunities and national/regional dietetic conferences should serve to enhance practice in population health promotion.
7. Program evaluation efforts at the community-level must be specific, measurable, culturally appropriate, realistic, and time-limited. It is important to move away from reductionist or behavioural paradigms to more expansionist approaches including participatory action research. Ideally, evaluation designs should include a broad range of process indicators along with both short- and long-term outcome measures.

11.6.3. Recommendations on Funding

1. Collaboration at the federal level should be increased among government departments with an interest and/or mandate in nutrition. Given the emphasis on a population health approach, it is necessary to establish the horizontal and vertical linkages necessary to integrate nutrition policy development and issues management with community-based health programming.
2. Secure long-term funding is a critical factor in determining whether community-based programs are sustainable. Successful coalition building requires community involvement in framing the initiative; multiple interventions targeting specific health conditions; funding for staff resources; and community capacity building.

Ideally, funding should cover the developmental costs necessary to set the stage for intersectoral collaborations as well as the costs incurred in implementing and consolidating the program.

3. Community organization is ultimately concerned with community-driven actions. While balancing the need for accountability, cost-effectiveness, and the implementation of a national evaluation framework, the funding agency must be willing to release control of actions or interventions to the community. Funders need to be cognizant of the need for flexibility and realistic timelines given the ever-changing needs of the community.
4. Involve other sectors in the development of broad national guidelines that cover a continuum of comprehensive health programming beginning with preconception and continuing through the preschool years. In this regard, integrate CPNP programs with other federally funded community-based programs targeting high-risk populations (e.g., Aboriginal Head Start) to ensure that there is continuity of services.
5. Expand the rationale for prenatal health beyond the prevention of low birth weight by increasing community/public awareness of the determinants of poor prenatal/birth outcomes and the resultant social and economic implications. Build community support for population health promotion approaches to improving prenatal and birth outcomes.
6. Develop a national clearinghouse of culturally appropriate, low literacy prenatal resources that have been used successfully by CPNP program practitioners across the country. Employ web-based technology to facilitate networking and information sharing among CPNP projects. Showcase innovative and effective collaborations among practitioners, the medical community, policy makers, and the media.
7. Combine both quantitative and qualitative methodologies in program evaluation and research designs. A variety of information, from different sources, provides illuminating evidence of program effectiveness. Well-designed qualitative data are required to complement the national CPNP evaluation.

11.6.4. Recommendations on Dietetic Education and Training

1. Additional collaborations between academic and dietetic professional associations are needed. Integrating systems of learning and encouraging cross-disciplinary approaches in undergraduate training can reduce fragmentation, improve communication about shared problems and high-risk populations, and help to incorporate nutrition expertise into community-based programming.
2. Dietetic students need to recognize how their own values and biases, and those of others, may influence their ability to work productively at the community-level. It is especially important that students critically reflect on their values and biases pertaining to the causes of poverty and disadvantage.
3. Preparation for work in population health requires knowledge about the determinants of health as well as competencies in community assessment, program planning and evaluation, participatory action research, interdisciplinary teamwork including mobilizing peer staff, cross-cultural communication, networking, and political action skills. It is not realistic to think that community dietitians can acquire this knowledge "on the job." Hence, it must be incorporated into the dietetics curricula at the undergraduate level.
4. Dietetic internship directors should actively investigate the potential of working collaboratively with CPNP national/regional staff and local project personnel to develop and implement comprehensive community nutrition placements for students completing postgraduate internship programs.

11.7. Recommendations for Future Research

The following recommendations for research are suggested:

1. This study was undertaken using a qualitative theoretical orientation. All research orientations contain assumptions, biases, and philosophical positions concerning the nature of reality. The application of a population health approach to prenatal nutrition programming is a relatively new phenomenon. Health Canada would benefit from additional research using a variety of perspectives to build a

substantial body of findings. This knowledge could provide a theoretical basis for policy-making in the area of prenatal health promotion.

2. The case study research on HSMM examined the functioning of one multi-faceted, highly collaborative city-wide program in the urban core of Winnipeg. Additional case studies, involving other CPNP projects, are necessary to elucidate the full range of programming options and to better understand the context in which projects have been operationalized across the country.
3. The case study research described the community organization process between 1995 and 2000 that resulted in the design, implementation, and consolidation of HSMM. Longitudinal studies could further enhance understanding of collaboration by studying existing efforts and refining qualitative and quantitative measures of both process and outcomes.
4. Additional community-based nutrition research is necessary to identify both short- and long-term indicators of program success. Short-term indicators could measure changes in participants' food preparation skills, self-confidence, and the "social capital" resulting from their participation in a community-based nutrition program.
5. Research on cost-effectiveness would strengthen the national CPNP evaluation framework and focus policy makers' attention on the significance of community-based programming in improving prenatal and birth outcomes.

11.8. Personal Reflections

Reflecting on my involvement with HSMM, I was deeply struck by the talented, committed, and caring individuals who have invested so much of themselves in the program over the past five years. Bound by a common vision of what was possible, and guided by the involvement of participant women and teens, they worked tirelessly and passionately to make the dream of HSMM a reality.

I was particularly impressed with the personal journeys of the three peer outreach workers--Paula, Diane, and Alice--as they made the transition from single mothers on social assistance to highly valued and respected members of the HSMM team. Their individual journeys were not easy. The peer outreach workers were constantly balancing stresses and hardships in their personal lives with the day-to-day challenges of their work with HSMM. In the process of becoming acquainted with Paula, Diane, and Alice, I was humbled by their courage, fortitude, and individual and collective wisdom. Additionally, I was struck by the unconditional support and understanding that they demonstrated to one another. In my opinion, HSMM's three peer outreach workers are truly remarkable women who serve as powerful role models to participant women.

I realized the depth of my connection to Paula, Diane, and Alice, when Paula enclosed a hand-written note with her transcript. Reading the note, I appreciated that Paula's sentiments about HSMM, and her personal journey of discovery, were very similar to my own. Her note read:

> *I am so thankful that HSMM has been part of my journey. I have learned so much through my experiences and my learning and growing continues. I know I have touched others, and I have been a part of other's journeys. What a gift to have given and received.*

In closing, I would like to express my gratitude to all those involved with HSMM who enthusiastically agreed to be part of my journey. Their personal stories touched me deeply and I am very grateful for their willingness to share so openly. Their generosity, professionalism, and dedication to improving the lives of participant women and their families will be my most enduring memory of this study.

REFERENCES

Abrams, D. B., Emmons, K. M., & Linnan, L. A. (1997). Health behavior and health education: The past, present, and future. In K. Glanz, F. M. Lewis, & B. K. Rimer (Eds.), Health behavior and health education (2nd ed.; pp. 453-478). San Francisco, CA: Jossey-Bass.

Achterberg, C. (1988). Qualitative methods in nutrition education evaluation research. J Nutr Educ, 20, 244-250.

Achterberg, C., & Clark, K. L. (1992). A retrospective examination of theory use in nutrition education. J Nutr Educ, 24, 227-233.

Ajzen, I. (1991). The theory of planned behaviour. Organizational behavior and human decision processes, 50, 179-211.

Ajzen, I., & Fishbein, M. (1980). Understanding attitudes and predicting social behavior. Englewood Cliffs, NJ: Prentice Hall.

Al, M. D. M., van Houwelingen, A. C., & Hornstra, G. (2000). Long-chain polyunsaturated fatty acids, pregnancy, and pregnancy outcome. Am J Clin Nutr, 71, 285S-291S.

Alexander, G. R., & Korenbrot, C. C. (1995). The role of prenatal care in preventing low birth weight. The Future of Children [On-line] *5*, 1-34. Available: http://www.futureofchildren.org/LBW/08LBWALE.htm

Alinsky, S. D. (1972). Rules for radicals. New York: Random House.

American Dietetic Association (1994). Position of the American Dietetic Association: Nutrition care for adolescents. J Am Diet Assoc, 94, 449-450.

Anderson, E. T., & McFarlane, J. (2000). Community as partner (3rd ed.). Philadephia, PA: Lippincott.

Arnstein, S. (1969). A ladder of citizen participation. Journal of American Institute of Planners (July), 216-224.

Bandura, A. (1969). Principles of behavior modification. New York: Holt.

Baranowski, T., Perry, C. L., & Parcel, G. S. (1997). How individuals, environments, and health behavior interact. In K. Glanz, F. M. Lewis, & B. K. Rimer (Eds.), Health behavior and health education: Theory, research, and practice (2nd ed.; pp. 153-178). San Francisco, CA: Jossey-Bass.

Barker, D. (1995). Fetal and infant origins of adult disease. BMJ 311, 171-174.

Barrington G., & Glacken, J. B. (1998a). Canada Prenatal Nutrition Program: IPQ 1997-1997 summary report. Calgary, AB: Author.

Barrington G., & Glacken, J. B. (1998b). Canada Prenatal Nutrition Program -- Manitoba region. Calgary, AB: Author.

Barrington Research Group, Inc. (2000). Information guide for the CPNP national evaluation strategy. Ottawa: Minister of Supply and Services Canada.

Beaulieu, M. D. (1994). Prevention of pre-eclampsia. In Canadian Task Force on the Periodic Health Exam (Ed.), The Canadian guide to clinical preventative health care. Ottawa: Minister of Supply and Services Canada.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). Women's ways of knowing: The development of self, voice, and mind. USA: Harper Collins.

Benson, A., & Latter, S. (1998). Implementing health promoting nursing: The integration of interpersonal skills and health promotion. Journal of Advanced Nursing, 27, 100-107.

Booth, M. (1998). This seems to work. Things that connect. Prepared for Dietitians of Canada National Conference, June 11, 1998. Winnipeg,: Healthy Start for Mom & Me.

Boyle, M. A., & Morris, D. H. (1994). Community nutrition in action: An entrepreneurial approach. St. Paul, MN: West.

Brassard, P., Robinson, E., & Dumont, C. (1993). Descriptive epidemiology of non-insulin diabetes mellitus in the James Bay Cree population of Quebec, Canada. Arctic Med Res, 52, 47-54.

Brookfield, S. D. (1986). Understanding and facilitating adult learning. San Francisco, CA: Jossey-Bass.

Bullock, L. F., & McFarlane, J. (1989). The birth-weight battering connection. Am J Nurs 89, 1153-1155.

Butterfield, P. G. (1990). Thinking upstream: Nurturing a conceptual understanding of the societal context of health behavior. Adv Nurs Sci, 12(2), 1-8.

Butterfoss, F. D., Goodman, R. M., Wandersman, A. (1993). Community coalitions for prevention and health promotion. Health Education Research, 8(3), 315-330.

Canada Prenatal Nutrition Program (CPNP)--Saskatchewan. (1999). The role of the registered dietitian: Guidelines. Regina, SK: Author.

Canadian Association of Food Banks. (1998). Hunger count 1998: A report on emergency food assistance in Canada. Toronto: Author.

Canadian Council on Social Development. (1998). The progress of Canada's children, 1998. Ottawa: Author.

Canadian Foundation for Dietetic Research, Dietitians of Canada, Kraft Canada. (1997). Speaking of food and eating: A consumer perspective. Toronto: Dietitians of Canada.

Canadian Institute for Advanced Research. (1999). Early Years Study: Final report. Toronto: Author.

Canadian Institute of Child Health. (1993). Prevention of low birthweight in Canada: Literature review and strategies. Prepared for the Ontario Ministry of Health Best Start Program. Ottawa: Author.

Canadian Institute of Child Health. (2000). The health of Canada's children (3rd ed.). Ottawa, ON: Author.

Canadian Public Health Association (1996). Action statement for health promotion in Canada. Ottawa: Author.

Caraher, M. (1994). Nursing and health promotion practice: The creation of victims and winners in a political context. Journal of Advanced Nursing 19(3), 465-468.

CDC/ATSDR Committee on Community Engagement. (December 1, 2000). Community engagement: definitions and organizing concepts from the literature. In Principles of Community Engagement [On-line]. Available: http://www.cdc.gov/phppo/pce/part1.htm.

Centre For Research in Social Policy. (1999). Evaluation of the Saffron Food and Health Project. Loughborough University, UK.

Chomitz, V. R., Cheung, L. W. Y., & Lieberman, E. (1995). The role of lifestyle in preventing low birth weight. The Future of Children [On-line] 5, 1-19. Available: http://www.futureofchildren.org/LBW/09LBWCHO.htm

Chu, R. C. (1985). Indirect costs of infant mortality and low birth weight [Report prepared for the National Commission to Prevent Infant Mortality, Washington, DC, May 1988] Washington, DC.

Ciliska, D., Hayward, S., Thomas, H., Mitchell, A., Dobbins, M., Underwood, J., Rafael, A., & Martin, E. (1994). The effectiveness of home visiting as a delivery strategy for public health nursing interventions: A systematic overview. Hamilton, ON: Quality of Nursing Worklife Research Unit (McMaster University, University of Toronto).

Clandinin, D. J., & Connelly, F. M. (1990). Stories of experience and narrative inquiry. Educational Researcher, 19, 2-14.

Creswell, J. W. (1998). Qualitative inquiry and research design. Thousand Oaks, CA: Sage.

da Silva, O. (1995). Prevention of low birth weight/preterm birth. The Canadian guide to preventative: the Canadian task force on the periodic health examination. Ottawa: Health Canada, 38-50.

Day, N. L., Jasperse, D., Richardon, G., et al. (1989). Prenatal exposure to alcohol: Effect on infant growth and morphologic characteristics. Pediatrics, 84, 536-541.

Denzin, N. K. (1997). Interpretative ethnography: Ethnographic practices for the 21st century. Thousand Oaks, CA: Sage.

DeSantis, L. (1994). Making anthropology clinically relevant to nursing care. Journal of Advanced Nursing, 20, 707-715.

Desrosiers Choquette, J., & Julien, M. (1998a). Canada Prenatal Nutrition Program (Part I) Review of the international literature: An internal report to Health Canada. Ottawa: Health Canada, Health Promotion & Programs Branch.

Desrosiers Choquette, J., & Julien, M. (1998b). Canada Prenatal Nutrition Program (Part II) Review of Canadian programs – An internal report to Health Canada. Ottawa: Health Promotion & Programs Branch, Health Canada.

Drevdahl, D. (1995). Coming to voice: The power of emancipatory community interventions. Adv Nurs Sci, 18, 13-24.

Dwyer, J. (1983). Impact of maternal nutrition on infant health. Medical Times, 111, 30-38.

Dyck, R. (2000). What some participants think: A report based on focus groups with moms. Unpublished manuscript.

Eakin, J., Robertson, A., Poland, B., Coburn, D., & Edwards, R. (1996). Towards a critical social science perspective on health promotion research. Health Promotion International 2(2), 157-165.

Edmonton Journal. (2000, October 17). Almost twice as many use food banks now as in 1989, A12.

Edwards, N., Sims-Jones, N., & Hotz, S. (1994). Pre- and postnatal smoking: A review of the literature. Ottawa: University of Ottawa, Community Health Research Institute.

Evans, R. G., Barer, M. L., & Marmor, T. (1994). Why are some people healthy and others not? New York: Aldine De Gruyter.

Federal, Provincial, and Territorial Advisory Committee on Population Health. (1994). Strategies for promoting population health. Ottawa: Minister of Supply and Services Canada.

Federal, Provincial, and Territorial Advisory Committee on Population Health. (1999a). Intersectoral Action…Towards Population Health. Ottawa: Minister of Public Works and Government Services Canada.

Federal, Provincial, and Territorial Advisory Committee on Population Health. (1999b). Toward a healthy future: Second report on the health of Canadians. Ottawa: Minister of Public Works and Government Services Canada.

Feighery, E., Rogers, T., Thompson, B., & Bracht, N. (1992). Coalition problem solving guide. Stanford, CA: Health Promotion Resource Centre, Stanford University.

Fishbein, M. (1990). AIDS and behaviour change: An analysis based on the theory of reasoned action. Interamerican Journal of Psychology, 24, 37-56.

Florin, P., Mitchell, R., Stevenson, J. (1993). Identifying training and technical assistance needs in community coalitions: A developmental approach. Health education Research, 8(3), 417-432.

Freire, P. (1971). Pedagogy of the oppressed. New York: Seaview.

Freire, P. (1973). Education for critical consciousness. New York: Seabury Press.

Geertz, C. (1973). Thick description: Toward an interpretative theory of culture. In C. Geertz (Ed.), The interpretation of cultures (pp. 3-30). New York: Basic Books.

Giacomi, J., Mosher, A., & Seaton-Wall, O. (1993). Ethnographic field methods and their relationship to design. In D. Schuler & A. Namioka (Eds.), Participatory design: Principles and practices. (pp. 235-155). Hillsdale, NJ: Lawrence Erlbaum.

Gibson, R. (1994). Iron concerns in Canada. NIN Review, Winter, 22.

Glesne, C. & Peshkin, A. (1992). Becoming qualitative researchers: An introduction. White Plains, NY: Lingman.

Globe & Mail. (1996, January 6). The diet divide, A6.

Globe & Mail. (1999, November 26). A singular lack of planning, A7.

Government of the Northwest Territories. (1999). The NWT status report 1999. Yellowknife: Author.

Gray, B. (1989). Collaborating: Finding common ground for multiparty problems. San Francisco, CA: Jossey-Bass.

Greenfield, T. (1993). Organizations as talk, change, action, and experience. In T. Greenfield & P. E. Ribbins (Eds.), Greenfield on educational administration. Toward a humane science. (pp. 53-73). New York: Routledge.

Guba, E. G. (1978). Toward a methodology of naturalistic inquiry in educational evaluation. (CSE Monograph Series in Evaluation No.8). Los Angeles: Centre for the Study of Evaluation.

Guba, E., G. (1981). Criteria for assessing the trustworthieness of naturalistic inquiries. ECTJ, 29, 75-91.

Health Canada, Medical Services Branch. (1996). Health programs analysis: First Nations and Inuit health programs. Ottawa: Minister of Supply and Services Canada.

Health Canada. (1994a). Strategies for population health: Investing in the health of Canadians. Ottawa: Minister of Supply and Services Canada.

Health Canada. (1994b). Strengthening prenatal health promotion for disadvantaged families. Ottawa: Minister of Supply and Services Canada.

Health Canada. (1995). Survey on smoking in Canada, Cycle 3. Ottawa: Minister of Supply and Services Canada.

Health Canada. (1997). Laboratory Centre for Disease Control. Bureau of HIV/AIDS and STD. Perinatally acquired HIV infection. HIV/AIDS Epi Update (November). Ottawa: Health Canada.

Health Canada. (1998a). Building partnerships for health: Lessons learned. Ottawa: Minister of Public Works and Government Services Canada.

Health Canada. (1998b). Taking action on population health. Ottawa: Population Health Directorate, Health Promotion and Programs Branch.

Health Canada. (1999a). Canada Prenatal Nutrition Program (CPNP) guide for applicants for the period April 1, 2000 to March 31, 2003. Ottawa: Minister of Public Works and Government Services Canada.

Health Canada. (1999b). Nutrition for a healthy pregnancy: National guidelines for the childbearing years. Ottawa: Minister of Public Works and Government Services Canada.

Health Canada. (2000). Information guide for the CPNP national evaluation strategy. Ottawa: Minister of Public Works and Government Services.

Health Canada. [On-line]. Available: http://www.hc-sc.gc.ca/english/ archives/ releases/preterm.htm.

Health and Welfare Canada. (1990). Nutrition recommendations: The report of the Scientific Review Committee. Ottawa: Minister of Supply and Services Canada.

Healthy Start for Mom & Me. (1996). Program proposal submitted to Health Canada. Winnipeg: Author.

Healthy Start for Mom & Me. (1998). The first year, 1997-1998. Winnipeg: Author.

Healthy Start for Mom & Me. (1999a). Data on HSMM participants. Winnipeg: Author.

Healthy Start for Mom & Me. (1999b). Summarized findings from participant feedback. Unpublished manuscript.

Healthy Start for Mom & Me. (2000). Orientation package for food preparation student volunteers. Unpublished manuscript.

Healthy Start for Mom & Me Bulletin. (1998, December). A lesson in words and labels, p. 1. The magic of food, p. 2. Winnipeg: Author

Healthy Start for Mom & Me Bulletin. (2000, July/August). Focus group findings from March 2000, p. 1. Winnipeg: Author.

Healthy Start for Mom & Me Bulletin. (2000, September). The power of gentleness and acceptance, p. 1. Winnipeg: Author.

Hughes, D., & Simpson, L. (1995). The role of social change in preventing low birth weight. The Future of Children [On-line] 5, 1-18. Available: http://www.futureofchildren.org/LBW/07LBWHUG.htm

Innis, S. M. (1991). Essential fatty acids in growth and development. Prog Lipid Res. 30, 39-103.

Israel, B. A., Checkoway, B., Schulz, A., & Zimmerman, M. (1994). Health education and community empowerment: Conceptualizing and measuring perceptions of individual, organizational and community control. Health Education Quarterly, 21, 149-170.

Israel, B. A., & Schurman, S. J. (1990). Stress, coping and health behavior. In K. Glanz & C. Lerman (Eds.), Health behavior and health education: Theory, research, and practice (2nd ed). (pp. 113-132). San Francisco, CA: Jossey-Bass.

Jezewski, M. A. (1995). Staying connected: The core of facilitating health care for homeless people. Public Health Nursing, 12(3), 203-210.

Joint Steering Committee Responsible for Development of a National Nutrition Plan for Canada. (1996). Nutrition for health: An agenda for action. Ottawa: Author. Available: http://www.hc-sc.gc.ca/nutrition

Katz, A. H. (1993). Self-help in America: A social movement perspective. New York: Twayne.

Keen, C., & Zidenberg-Cherr, S. (1994). Should vitamin-mineral supplements be recommended for all women with childbearing potential? Am J Clin Nutr, 59, 532s-539s.

Kelle, U. (1995). Computer-aided qualitative data analysis. London: Sage.

Kent, G. (1988). Nutrition education as an instrument of empowerment. Journal of Nutrition Education 20, 193-195.

Ketting, E., & Visser, A. P. (1994). Contraception in the Netherlands: The low abortion rate explained. Patient Education and Counselling, 23, 166-171.

King, M., Harrison, M. J., & Reutter, L. I. (1995). Public health nursing or community health nursing: What's in a name? In M. Stewart (Ed.), Community nursing: Promoting Canadians' health. (pp. 400-412). Toronto, ON: W. B. Saunders.

Korenbrot, C. C., Showstack, J., Loomis, A., & Brindis, C. (1989). Birth weight outcomes in a teenage pregnancy case management project. J Adoles Health Care 10, 97-104.

Kramer, M. (1987). Determinants of low birthweight: Methodological assessment and meta-analysis. Bulletin of the World Health Organization, 65, 663-737.

Kramer, M. (1998). Maternal nutrition, pregnancy outcome, and public health policy. Canadian Medical Association Journal, 159, 663-665.

Kulig, J. C. (2000). Culturally diverse communities: The impact on the role of community health nurses. In M. J. Stewart (Ed.), Community nursing: Promoting Canadians' health (2nd ed.; pp. 194-210). Toronto, ON: W. B. Saunders.

Labonte, R. (1993). Chapter 2: Exploring health; Chapter 4: The Empowerment Holosphere. In Issues in health promotion series, #3, Health promotion and empowerment: practice frameworks (pp. 31-36, 59-84). Toronto, ON: University of Toronto, Centre for Health Promotion, & Participaction.

Labonte, R. (1994). Health promotion and empowerment: Reflections on professional practice. Health Education Quarterly, 21, 253-268.

Laffrey, S. C., & Craig, D. M. (2000). Health promotion for communities and aggregates: An integrated model. In M. J. Stewart (Ed.), Community nursing: Promoting Canadians' Health (2nd ed.; pp. 105-125). Toronto, ON: W. B. Saunders.

Laffrey, S. C., & Kulbok, P. (1999). An integrative model for holistic community health nursing. Journal of Holistic Nursing, 17(1), 88-103.

Laschinger, H. K. S., & Weston, W. (1995). Role perceptions of freshman and senior nursing and medical students toward collaborative decision-making. Journal of Professional Nursing, 11(2), 119-128.

Lebrun, J. B., Moffatt, M. E. K., Mundy, R. J. T., Sangster, R. K., Postl, B. D., Dooley, J. P., Dilling, L. A., Godel, J. C., & Haworth, J. C. (1993). Vitamin D deficiency in a Manitoba community. Can J Public Health, 84, 394-396.

Levine, R. J., Hauth, J. C., Curet, L. B., Sibai, B. M., Catalano, P. M., Morris, C. D., DerSimonian, R., Esterlitz, J. R., Raymond, E. G., Bild, D. E., Clemens, J. D., & Cutler J. A. (1997). Trial of calcium to prevent pre-eclampsia. N Engl J Med, 37, 69-76.

Lewit, E. M., Baker, L. S. Corman, H., & Schiono, P. H. (1995). The direct cost of low birth weight. The Future of Children [On-line] 5, 1-38. Available: http://www.futureofchildren.org/LBW/04LBWLEW.htm

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic Inquiry. Beverly Hills, CA: Sage.

Lister, L. (1980). Role expectations of social workers and other health professionals. Health and Social Work, 5(2), 41-49.

Loche, L. F. (1987). Preparation of proposals for qualitative research. In L. F. Loche, W. W. Spirudiso, & Silverman, S. J. (Eds.), Proposals that work: A guide for planning dissertations and grant proposals (pp. 83-97). Newbury Park, CA: Sage.

Mariano, C. (1988). The case for interdisciplinary collaboration. Nursing Outlook, 37, 285-288.

Marshall, C., & Rossman, G. B. (1995). Designing qualitative research (2nd ed.). Thousand Oaks, CA: Sage.

Matheson, L. & Wylie, G. (2000, July). The Canada Prenatal Nutrition Program: A healthy start. Paper presented at the International Congress of Dietetics, Edinburgh, Scotland.

McFarlane, J., & Fehir, J. (1994). De Madres a Madres: A community, primary health care program based on empowerment. Health Education Quarterly, 21, 381-394.

McKinlay, J. B. (1992). Health promotion through healthy public policy: The contribution of complementary research methods. Canadian Journal of Public Health, 83, S11-S15.

McKnight, J. (1995). The careless society. Community and its counterfeits. New York: Basic Books.

McKnight, J., & Dover, L. V. (1994). Community as client: A challenge for nursing education. Public Health Nursing, 11(1), 12-16.

McKnight, J. L., & Kretzmann, J. P. (1997). Mapping community capacity. In M. Minkler (Ed.), Community organizing & community building for health (pp. 157-172). New Brunswick, NJ: Rutgers.

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. Health Education Quarterly, 15(4), 351-377.

Meltzer, S., Leiter, L., Daneman, D., Gerstein, H., Lau, D., Ludwig, S., Yale J.-F., Zinman, B., Lillie, D., Steering and Expert Committees. (1998). CDA 1998 clinical practice guidelines for the management of diabetes in Canada. CMAJ, 159(8Suppl), S1-S29.

Merriam, S. (1988). Case study research in education: A qualitative approach. San Francisco: Jossey-Bass.

Miles, M. B., & Huberman, A. M. (1994). Qualitative data analysis: An expanded sourcebook. Thousand Oaks, CA: Sage.

Miles, M. B., & Huberman, A. M. (1999). Qualitative data analysis: An expanded sourcebook (2nd ed.). Thousand Oaks, CA: Sage.

Milio, N. (1981). Promoting health through public policy. Philadelphia: F. A. Davis.

Mills, J. L., Graubard, B. I., Harley, E. E., et al. (1984). Maternal alcohol consumption and birth weight: How much drinking during pregnancy is safe? JAMA, 252, 1875-1879.

Minkler, M., & Pies, C. (1997). Ethical issues in community oranization and community participation. In M. Minkler (Ed.), Community organizing & community building for health (pp. 120-136). New Brunswick, NJ: Rutgers.

Minkler, M., & Wallerstein, N. (1997). Improving health through community organizing and community building. In K. Glanz, F. M. Lewis, & B. K. Rimer (Eds.), Health behavior and health education: Theory, research and practice (2nd ed.; pp. 241-269). San Francisco, CA: Jossey-Bass.

Montano, D. E., & Taplin, S. H. (1991). A test of an expanded theory of reasoned action to predict mammography participation. Social Science and Medicine, 32, 733-741.

Morgan, G. (1997). Images of organization. Thousand Oaks, CA: Sage.

Moutquin, J. M., Milot-Roy, V., & Irion, O. (1996). Preterm birth prevention: effectiveness of current strategies. Journal SOGC, 8, 571-588.

Murphy, S. (1993). Healthy eating makes a difference: A food resource book for people living with HIV. Ottawa: Canadian Hemophilia Society.

Mustard, C. & Roos, N. (1994). The relationship of prenatal care and pregnancy complications to birthweight in Winnipeg, Canada. Am J Public Health (84), 1450-1457.

Mustard, F. J., & Frank, J. (1991). The determinants of health. Canadian Institute for Advanced Research Publication #5. Toronto.

National Academy of Sciences. (1990). Nutrition during pregnancy. Part 1: Weight gain. Part 2: Nutrient supplements. Washington, DC: Institute of Medicine, Food and Nutrition Board, Committee on Nutritional Status During Pregnancy and Lactation, Subcommittee on Dietary Intake and Nutrient Supplements During Pregnancy, Subcommittee on Nutritional Status and Weight Gain During Pregnancy.

National Council of Welfare. (1997). Healthy parents, healthy babies. Ottawa: Minister of Public Works and Government Services Canada.

Nechi Training & Health Promotion Institute. (1999). Seven sacred teachings. Edmonton: Author.

Northouse, L. L., & Northouse, P. G. (1998). Health communication: Strategies for health professionals. Stamford, CT: Appleton & Lange.

Nova Scotia Heart Health Program, Nova Scotia Department of Health, Health and Welfare Canada. (1993). Report of the Nova Scotia nutrition survey. Halifax: Nova Scotia Department of Health.

O'Connor, D. L. (1995). The folate status of Canadian women. In G. Koren (Ed.), Folic acid for the prevention of neural tube defects (pp. 73-87). Toronto: The Motherisk Program.

Olds, D. L., Henderson, C. R., Kitzman, J., Eckenrode, J. J., Cole, R. E., & Tatelbaum, R. C. (1999). Prenatal and infancy home visitation by nurses: Recent findings. The Future of Children 9, 45-65.

Olds, D. L., Henderson, C. R., Tatelbaum, R., & Chamberlin, R. (1986). Improving the delivery of prenatal care outcomes of pregnancy: A randomized trial of nurse home-visitation [published erratum appears in Pediatrics 1986, 78(1), 138]. Pediatrics, 77, 16-18.

Ontario Dietetic Association (Working Group of the Community Dietitians in Health Centres Provincial Interest and Practice Group). 1993. Discussion paper on the evolving role of dietitians in community health centres. Toronto: Author.

Osborne, C. G., McTyre, R. B., Dudek, J., Roche, K. E., Scheuplein R., Silverstein, B., Weinberg, M. S., & Salkeld, A. A. (1996). Evidence for the relationship of calcium to blood pressure. Nutr Rev, 54, 365-381.

Patton, M. Q. (1987). How to use qualitative methods in evaluation (2nd ed. Newbury Park, CA: Sage.

Pearson, P. (1992). Defining the primary care team. Health Visitor, 65(10), 358-361.

Perinatal Education Program of Eastern Ontario. (1998). Prevention of low birth weight in Canada: Literature review and strategies (2nd ed.). Toronto: Best Start Resource Centre.

Poulton, B. C., & West, M. A. (1993). Effective multidisciplinary teamwork in primary health care. Journal of Advanced Nursing, 18, 918-925.

Preston, A. M. (1991). Cigarette smoking: Nutritional implications. Prog Food Nutr Sci, 15, 183-217.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. American Psychologist, 47, 1102-1114.

Prochaska, J. O., Redding, C. A., & Evers, K. E. (1997). The transtheoretical model and stages of change. In K. Glanz, F. M. Lewis, & B. K. Rimer (Eds.), Health behavior and health education: Theory, research, and practice (2nd ed.; pp. 60-84). San Francisco, CA: Jossey-Bass.

Quinby, P. M., & Graham, A. V. (1993). Substance abuse among women. Prim Care, 20, 31-39.

Rachlis, M. (1999). Intersectoral action for health : A paper prepared for the Advisory Committee on Population Health. Available: http//www.health-santecanada.net

Rees, J., M., & Worthington-Roberts, B. (1994). Position of the American Dietetic Association: Nutrition care for pregnant adolescents. J Am Diet Assoc 94, 449-450.

Reutter, L. I. (2000). Socioeconomic determinants of health. In M. J. Stewart (Ed.), Community nursing: Promoting Canadians' health (2nd ed.; pp. 174-193). Toronto, ON: W. B. Saunders.

Rich, R. C., Edlestein, M., Hallman, W. K., & Wandersman, A. H. (1995). Citizen participation and empowerment: The case of local environmental hazards. American Journal of Community Psychology, 23(5), 657-676.

Richardson, G. (1995). A welcome for every child. A report of the French-American Foundation (pp. 1-61).

Ritchie, J. E. (1994). Education for primary health care: Accommodating the new realities. World Health Forum, 15(2), 147-149.

Robertson, A. & Minkler, M. (1994). New health promotion movement: A critical examination. Health Education Quarterly, 21, 295-312.

Rosenberg, M.J. (1956). Cognitive structure and attitudinal affect. Journal of Abnormal and Social Psychology, 53, 367-372.

Rosenstock, I. M., Strecher, V. J., & Becker, M. H. Social learning theory and the health belief model. Health Education Quarterly, 15, 175-183.

Rosenthal, B. B. (1998). Collaboration for the nutrition field: Synthesis of selected literature. Journal of Nutrition Education 30(5), 246-267.

Ross, D. P., Scott, K., & Kelly, M. (1996). Child poverty: What are the consequences? Ottawa: Canadian Council on Social Development.

Rothman, J. (1979). Three models of community organization process. In F. M. Cox, J. L. Erlich, J. Rothman, & J. E. Tropman (Eds.), Strategies of community organization: A book of readings (pp. 86-102). Itasca, IL: Peacock.

Rothman, J. (1996). The interweaving of community intervention approaches. In M. Weil (Ed.), Community practice: Conceptual models (pp. 69-99). New York: Hawthorne.

Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. Psychological Monographs, 80(1), 1-28.

Rubin, H., & Rubin, I. (1992). Community organizing and development (2nd ed.). New York: Macmillan.

Rush, K. L. (1997). Health promotion ideology and nursing education. Journal of Advanced Nursing, 25, 1292-1298.

Saigal, S., Feeny, D., Furlong, W., Rosenbaum, P., Burrows, E., & Torrance, G. (1994). Comparison of the health-related quality of extremely low birth weight children and a reference group at age 8 years. J Pediatr, 125, 418-35.

Saskatchewan Health. (1999). Population health promotion practice in the primary prevention of type 2 diabetes. Regina, SK.

Saugstad, L. F. (1981). Weight of all births and infant mortality. J Epidemol Community Health 35, 185-191.

Scott, D. (1996). Ethnography and education. In D. Scott & R. Usher (Eds.) Understanding educational research (pp. 143-157). London: Routledge.

Silverman, D. (1993). Interpreting qualitative data: Methods for analysing talk, text, and interaction (pp. 144-147). London: Sage.

Single, E., Robson, L., & Xie, X. (1995). The cost of substance abuse in Canada. Ottawa: Canadian Centre on Substance Abuse.

Social Planning Council Of Winnipeg. (1999). The Manitoba 1999 child poverty report card: An agenda for action. Winnipeg, MB: Author.

Stake, R. (1987). The case study method of social inquiry. Educational Researcher, 7, 5-8.

Stake, R. (1994). Case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 235-247). Thousand Oaks, CA: Sage.

Stake, R. (1995). The art of case study research. Thousand Oaks, CA: Sage.

Statistics Canada & Canadian Centre for Justice Statistics (1998). Family violence in Canada: A statistical profile. Ottawa: Author (Statistics Canada Cat. No.85-224-XPE).

Statistics Canada. (1993). Language, tradition, health, lifestyle and social issues. Aboriginal Peoples Survey, 1991. Ottawa: Statistics Canada.

Statistics Canada. (1994a). Violence against women survey. Ottawa: Author.

Statistics Canada. (1994b). Wife assault: The findings of a national survey. Juristat Service Bulletin14, 1-22.

Statistics Canada. (1996). Reproductive health: Pregnancies and rates, Canada, 1974-1993. Health Reports. Ottawa: Ministry of Industry.

Statistics Canada. (1996-97). National population health survey. Ottawa: Minister of Public Works and Government Services.

Statistics Canada. (1997). Income distributions by size in Canada 1996. Ottawa: Minister of Industry, Science and Technology.

Statistics Canada. (1998, July 8). Births 1996. The Daily (Statistics Canada Cat. No. 11-001-XIE).

Stevens, P. E., & Hall, J. M. (1992). Applying critical theories to nursing in communities. Public Health Nursing , 9(1), 2-9.

Stevens, S. (1993). Community based programs for a multicultural society: A guidebook for service providers. Winnipeg, MB: Planned Parenthood Manitoba.

Stewart, M. J. (1990a). From provider to partner: A conceptual framework for nursing education based on primary health care premises. Adv Nurs Sci, 12(2), 9-27.

Stewart, M. J. (1990b). Professional interface with mutual aid self-help groups: A review. Social Science and Medicine, 31, 1143-1158.

Stewart, M. J. (2000). Social support, coping, and self-care as public participation mechanisms. In M. J. Stewart (Ed.), Community nursing: Promoting Canadians' health (2nd ed.; pp. 83-104). Toronto, ON: W. B. Saunders.

Stewart, M. J., Gillis, A., Brosky, G., Johnston, G., Kirkland, S., Leigh, G., Persaud, V., Rootman, I., Jackson, S., & Pawliw-Fry, B. A. (1996). Smoking among disadvantaged women: Causes and cessation. Canadian Journal of Nursing Research 28, 41-60.

Strecher, V. J., & Rosenstock, I. M. (1997). The health belief model. In K. Glanz, F. M. Lewis, & B. K. Rimer (Eds.), Health behaviour and health education: Theory, research, and practice (2nd ed.; pp. 41-59). San Francisco, CA: Jossey-Bass.

Tarasuk, V., Beaton, G. H., Geduld, J., & Hilditch, S. (1998). Nutritional vulnerability and food insecurity among women and families using food banks. Unpublished paper, Health Canada, National Health Research and Development Program (NHRDP). Project No. 6606-5609-201.

Tesh, S. N. (1988). Hidden arguments. Political ideology and disease prevention policy. New Brunswick, NJ.: Rutgers University Press.

Thoits, P. (1995). Stress, coping, and social support processes: Where are we? What next? Journal of Health and Social Behavior (special number), 53-79.

Thompson, B., & Kinne, S. (1990). Social change theory: Applications to community health. In N. Bracht (Ed.), Health promotion at the community level. Newbury Park, CA: Sage.

Thompson, B., & Kinne, S. (1999). Social change theory: Applications to community health. In N. Bracht (Ed.), Health promotion at the community level (2nd ed.; pp. 29-46). Thousand Oaks, CA: Sage.

Tilden, V. P., & Weinert, C. (1987). Social support and the chronically ill individual. Nursing Clinics, 22(3), 613-620.

Travers, K. D. (1994). Nutrition experiences of low income women. Canadian Journal of Obstetrics/Gynecology and Women's Health Care, 6, 691-697.

Travers, K. D. (1996). The social organization of nutritional inequities. Soc. Sci. Med. 43, 543-553.

Travers, K. D. (1997a). Nutrition education for social change: A critical perspective. Journal of Nutrition Education, 29, 57-62.

Travers, K. D. (1997b). Reducing inequities through participatory research and community empowerment. Health Education & Behaviour, 24, 344-356.

United Nations. (1992). Demographic year books, 1985-1989. Geneva: Author.

United Nations International Children's Emergency Fund (UNICEF). (1998). The state of the world's children 1998. Oxford & New York: Oxford University Press.

Visser, M. (1986). Much depends on dinner. Toronto, ON: McClelland and Stewart.

Wallerstein, N. (1992). Powerlesssness, empowerment, and health: Implications for health promotion programs. American Journal of Health promotion 6(3), 197-205.

Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. Health Education Quarterly, 15, 379-394.

Wallerstein, N., & Sanchez-Merki, V. (1994). Freirian praxis in health education: Research results from an adolescent prevention program. Health Education Research Theory & Practice, 9, 105-118.

Werler, M. M., Shapiro, S., & Mitchell, A. A. (1993). Periconceptual folic acid exposure and risk of occurrent neural tube defects. J Am Med Assoc, 269, 1257-1261.

Wilkinson, R., & Marmot, M. (1998). Social determinants of health: The solid facts. Geneva, Switzerland: World Health Organization Regional Office for Europe.

Wilkinson, R. G. (1999). The culture of inequality. In I. Kawachi, B. P. Kennedy, & R. G. Wilkinson (Eds.), The society and population health reader: Income equality and health. (pp. 492-498). New York, NY: The New Press.

Winnipeg Free Press. (2000a, September 2). Advertisement [On-line]. Available: sp_Advertising@freepress.mb.ca

Winnipeg Free Press. (2000b, September 9). Special teaching planned for fetal alcohol sufferers, p. 11.

Winnipeg Prenatal Nutrition Initiative Steering Committee (1996). Healthy Start for Mom & Me Funding Proposal. Prepared for Health Canada (Canada Prenatal Nutrition Program). Winnipeg: Author.

World Health Organization. (1997). The Jakarta declaration on leading health promotion into the 21st century. Jakarta: Author.

World Health Organization European Working Group on Health Promotion Evaluation (1998). Health promotion evaluation: Recommendations to policymakers. Geneva: WHO.

World Health Organization, Health Canada, and Canadian Public Health Association. (1986). Ottawa Charter for Health Promotion. Copenhagen: WHO.

Wylie, G. (1998). Blue jean teams. In Organization for Nutrition Education Bulletin, 17(2).

Yin, R. K. (1989). Case study research: Design and method. Newbury Park: CA: Sage.

Zerwekh, J. (1991). A family caregiving model for public health nursing. Nursing Outlook, 39, 213-217.

APPENDIX A

NATIONAL CPNP EVALUATION FRAMEWORK

CANADA PRENATAL NUTRITION PROGRAM

Evaluation Framework

Evaluation Objects	Evaluation Questions	Information source	Program Indicators
1. PROGRAM RELEVANCE			
1.1 To determine the continued need for the CPNP at the Federal level.	1. After four years of implementation, do the conditions that led to the creation of the CPNP still exist and justify the continuation of a program at the Federal level dedicated to the issue of prenatal nutrition?	Baseline study	Birth weight rates (non CPNP) Infant health (non-CPNP) Material health (non-CPNP) Breastfeeding rates/
		Statistics Canada, Health Reports	National rates
	2. Does the CPNP duplicate other Federal programs inside or outside Health Canada?	IPQ	Program overlap
	3. How and to what extent does the CPNP complement or expand upon other prenatal programs addressing the same issue at the provincial, municipal and community levels.	IPQ	Program overlap
	4. Is the CPNP still the appropriate type of intervention? Should the federal government continue to be involved or could equally satisfactory results be delivered by another level of government and/or the private or voluntary sector?	IPQ	Sustainability/Community Ownership

Evaluation Objects	Evaluation Questions	Information source	Program Indicators
2. IMPLEMENTATION PROCESS			
2.1 *To determine if the CPNP reached its target groups*	1. Has the CPNP reached the intended target groups (including First Nations and Inuit)? If not, why not? 2. What have the participation rates been?	IPQ IPQ	Target population Target population Program completion/ cooperation
2.2 *To determine if the CPNP increased accessibility of services*	1. Has the CPNP increased the accessibility of services for mothers and babies who are: a) Less adequately served physically (e.g., high density urban areas, isolated rural/northern areas) b) Less adequately served culturally	IPQ IPQ ICQ IPQ ICQ	Target population Target population Client Utilization of Project Services Target population Client Utilization of Project Services
2.3 *To determine if the CPNP provided appropriate program management*	1. Were appropriate systems or mechanisms established to coordinate, monitor and evaluate Program activities? 2. What were the strengths and weaknesses of the approach used for Program implementation?	Document Review Interviews, Senior Staff Stakeholder Focus Groups Interviews, Senior Staff Stakeholder Focus Groups Unobtrusive/Emergent Measures	Level of collaboration Incidence of crisis management Stakeholder satisfaction Evaluation products (quality, appropriateness) Emergent
2.4 *To determine the nature of partnerships which were developed by CPNP projects*	1. What evidence is there that the projects have developed partnerships and cooperative relationships with other organizations (public or private), groups or individuals within their community? 2. Did CPNP increase the support by the community regarding the needs, interests and rights of at-risk mothers and infants?	IPQ IPQ	Partnerships Spin-offs Collaboration

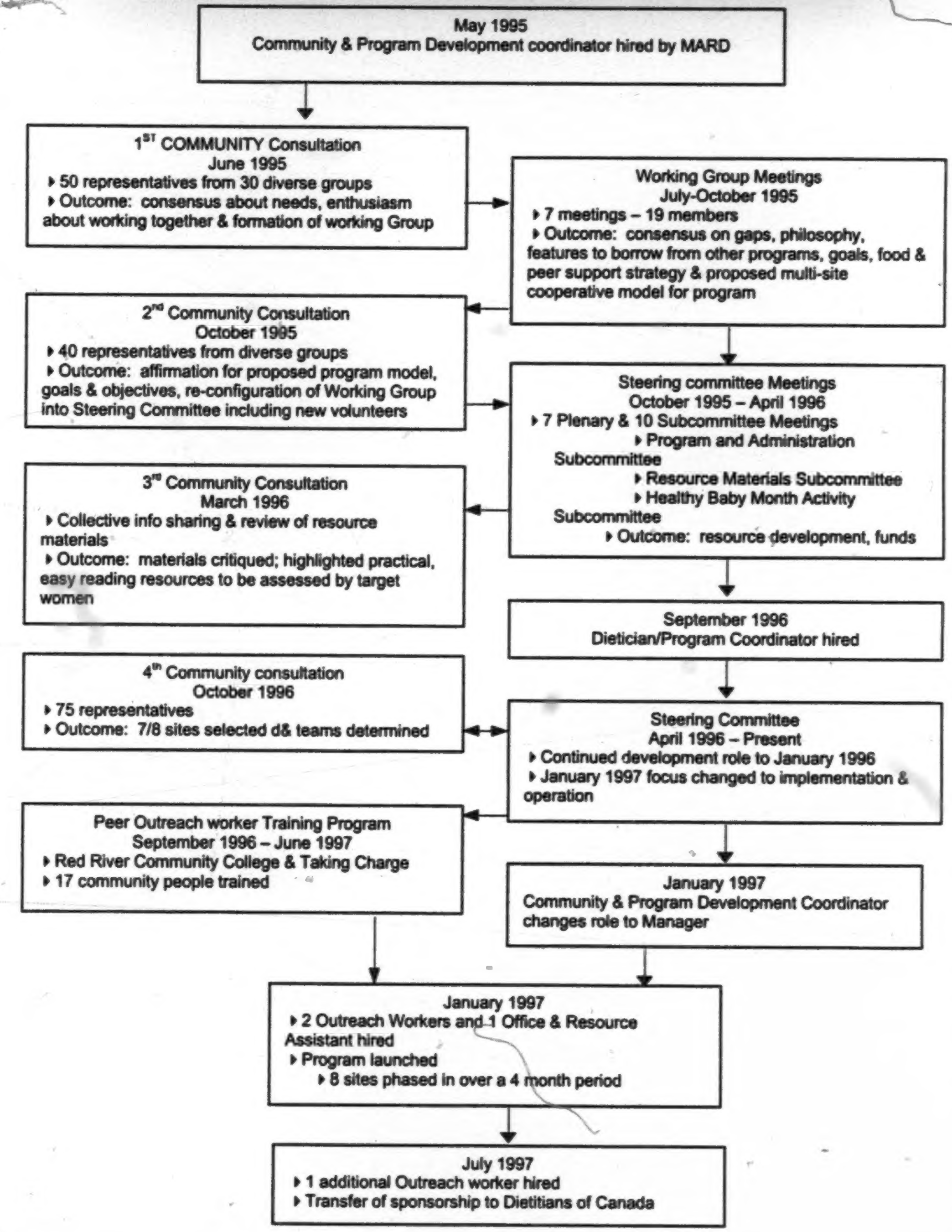
Evaluation Objects	Evaluation Questions	Information	Program Indicators
3.0 PROGRAM SUCCESS			
3.1 To determine the impact of the CPNP on pregnancy outcomes	1. What evidence is there that the projects supported by the CPNP have had the desired effect on pregnancy outcomes, including:		
	a) Birth weight	IPQ	Birth weight rates
	b) Infant health	ICQ	Infant outcomes
	c) Maternal health	ICQ	Maternal outcomes
	d) Breastfeeding	IPQ	Breastfeeding rates/duration
3.2 To determine the effectiveness of various types of CPNP projects and activities	1. Which types of projects and project activities were more effective in improving pregnancy outcomes?	IPQ/ICQ	Statistical Analysis: Project type by outcomes Project activity by outcomes
	2. What lessons can be learned from these projects?	Case Studies	Emergent from site visits
		IPQ	Anecdotal information
		Case Studies	Emergent from site visits
4.0 COST EFFECTIVENESS			
4.1 To determine if the CPNP is cost effective	1. What would the costs have been without the CPNP?	Literature review	Cost per LBW baby x # LBW babies in Canada (96-98)
	2. Are there other cost-effective ways of delivering the local programs/projects?	Baseline study	LBW comparisons (CPNP/ non-CPNP communities)
		IPQ	Cost per client

Source: Barrington Research Group, Inc., 1998,

APPENDIX B

HEALTHY START FOR MOM & ME DEVELOPMENTAL MODEL

Healthy Start for Mom & Me – Developmental Process



May 1995
Community & Program Development coordinator hired by MARD

1ST COMMUNITY Consultation
June 1995
- 50 representatives from 30 diverse groups
- Outcome: consensus about needs, enthusiasm about working together & formation of working Group

Working Group Meetings
July-October 1995
- 7 meetings – 19 members
- Outcome: consensus on gaps, philosophy, features to borrow from other programs, goals, food & peer support strategy & proposed multi-site cooperative model for program

2nd Community Consultation
October 1995
- 40 representatives from diverse groups
- Outcome: affirmation for proposed program model, goals & objectives, re-configuration of Working Group into Steering Committee including new volunteers

Steering committee Meetings
October 1995 – April 1996
- 7 Plenary & 10 Subcommittee Meetings
  - Program and Administration Subcommittee
  - Resource Materials Subcommittee
  - Healthy Baby Month Activity Subcommittee
  - Outcome: resource development, funds

3rd Community Consultation
March 1996
- Collective info sharing & review of resource materials
- Outcome: materials critiqued; highlighted practical, easy reading resources to be assessed by target women

September 1996
Dietician/Program Coordinator hired

4th Community consultation
October 1996
- 75 representatives
- Outcome: 7/8 sites selected d& teams determined

Steering Committee
April 1996 – Present
- Continued development role to January 1996
- January 1997 focus changed to implementation & operation

Peer Outreach worker Training Program
September 1996 – June 1997
- Red River Community College & Taking Charge
- 17 community people trained

January 1997
Community & Program Development Coordinator changes role to Manager

January 1997
- 2 Outreach Workers and 1 Office & Resource Assistant hired
- Program launched
  - 8 sites phased in over a 4 month period

July 1997
- 1 additional Outreach worker hired
- Transfer of sponsorship to Dietitians of Canada

Source: HSMM, 1987, p. 1.

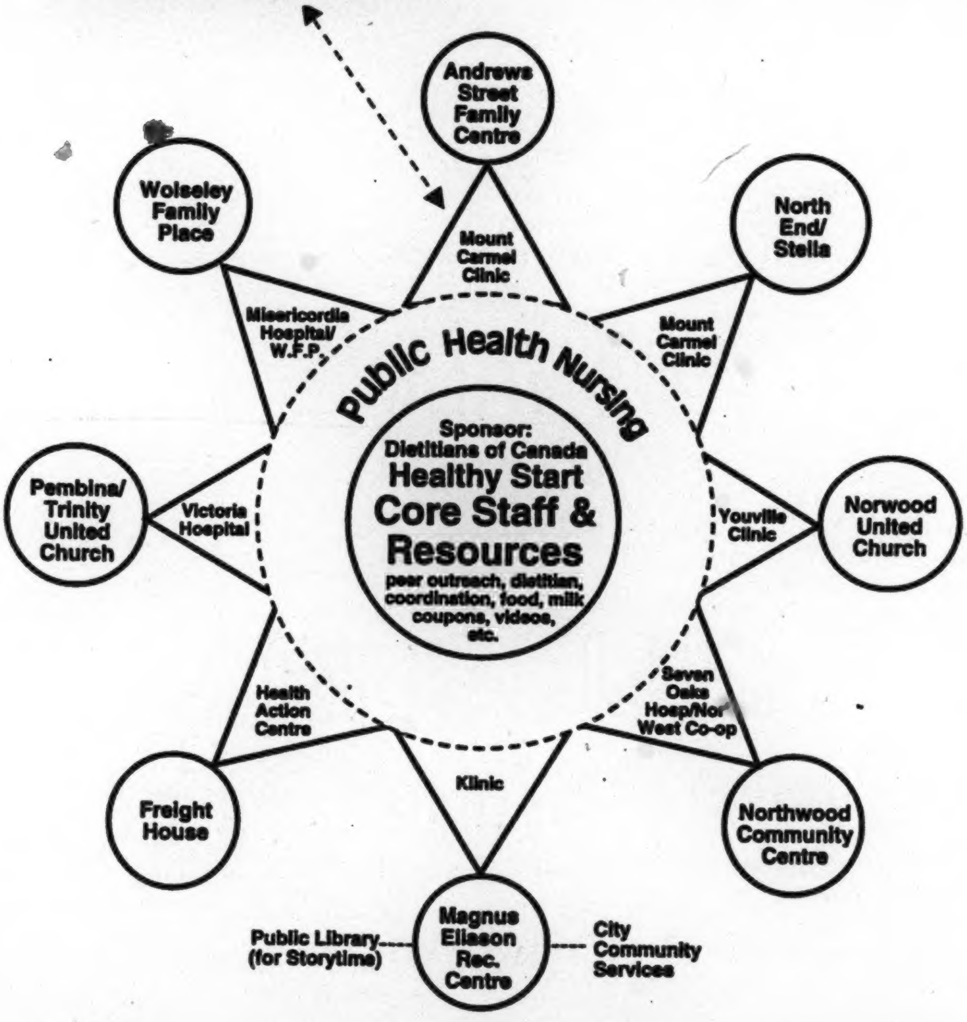
APPENDIX C

HEALTHY START FOR MOM & ME COLLABORATIVE MODEL

The Healthy Start Collaborative Outreach Model

To low income, isolated pregnant teens & women & new parents

- **Community sites, 8 locations**
- **Organization listed in each point of the star contributes staff**



Andrews Street Family Centre

Mount Carmel Clinic

North End/ Stella

Mount Carmel Clinic

Norwood United Church

Youville Clinic

Northwood Community Centre

Seven Oaks Hosp/Nor West Co-op

Magnus Eliason Rec. Centre

Public Library (for Storytime)

City Community Services

Klinic

Freight House

Health Action Centre

Pembina/ Trinity United Church

Victoria Hospital

Wolseley Family Place

Misericordia Hospital/ W.F.P.

Public Health Nursing

Sponsor: Dietitians of Canada

Healthy Start Core Staff & Resources

peer outreach, dietitian, coordination, food, milk coupons, videos, etc.

Each team is composed of: Peer Outreach Worker, Dietitian (contributed or from core staff), and a contributed Public Health Nurse at minimum.

Source: HSMM, 1999, p.

APPENDIX D

INFORMATION LETTER AND CONSENT FORM--PARTICIPATION OBSERVATION

Information Letter for Participant Observation

Title of the Project:

A Case Study of Healthy Start For Mom & Me: A Prenatal Nutrition Program Based On Education, Participation and Capacity Building.

Researchers:

Ellen Vogel	Kim Raine-Travers (Advisor)
Ph.D. Student	Associate Professor
Phone #: (780) 451-7632 or (204) 949-5354	Phone #: (780) 492-7584

Faculty of Agriculture, Forestry and Home Economics
University of Alberta, Edmonton, AB

Purpose of the study?

The information is being collected for use in a research study on Healthy Start for Mom & Me. The purpose of the study is to describe Healthy Start for Mom & Me through the experiences of participants, program staff and community partners. The information collected will help Healthy Start for Mom & Me provide better services for pregnant women.

What will happen?

In order to understand how the program works the researcher will collect information in many ways. Healthy Start for Mom & Me participants attending drop-in sessions will be observed by the researcher at two sites. The two sites are Northwood Community Centre at 1415 Burrows Street and Magnus Eliason Recreation Centre at 430 Langside Street. The researcher will take notes while observing the drop-in sessions to remember the important points.

Benefits and risks of participation?

The benefits to the research include sharing ideas and experiences to better understand how Healthy Start for Mom & Me operates. The information will help staff to improve the program and make sure that it continues to meet the needs of participants. There are no known risks to participating in the study.

Is the information collected confidential?

All personal information will be removed from written and spoken study information. Only the researcher will be able to obtain personal information. Information collected will be kept in a locked filing cabinet in the researcher's office. All information that can link people to the study will be destroyed after reports are written.

All study participants are free to withdraw from the study at any time without any result.

Title of Project: A Case Study of Healthy Start for Mom & Me: A Prenatal Nutrition Program Based On Education, Community Participation, and Capacity Building.

Principal Investigator (Advisor)	Co-investigator (Student Researcher)
Kim Raine-Travers	Ellen Vogel
Associate Professor	Ph.D. Student
Phone #: (780) 492-7584	Phone #: (780) 451-7632 or (204) 949-5354

Faculty of Agriculture, Forestry and Home Economics
University of Alberta, Edmonton, AB

Part II (to be completed by the research participant)

Do you understand that you have been asked to be in a research study? ☐ yes ☐ no

Have you read and received a copy of the attached Information Sheet? ☐ yes ☐ no

Do you understand the benefits and risks involved in taking part in this research study? ☐ yes ☐ no

Have you had an opportunity to ask questions and discuss this study? ☐ yes ☐ no

Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason. ☐ yes ☐ no

Has the issue of confidentiality been explained to you? ☐ yes ☐ no

Do you understand how the information collected in the study will be used? ☐ yes ☐ no

This study was explained to me by: ______________________________

I agree to take part in this study.

______________________	______________	______________________
Signature of Research Participant	Date	Witness
______________________		______________________
Printed Name		Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM

APPENDIX E

INFORMATION LETTER AND CONSENT FORM–TRAINED FACILITATOR OF FOCUS GROUPS

Information Sheet for Trained Facilitator of Focus Groups

Title of the Project:

A Case Study Of Healthy Start For Mom & Me: A Prenatal Nutrition And Health Promotion Program Based On Education, Participation And Capacity Building.

Researchers:

Ellen Vogel (Student Researcher)	Kim Raine-Travers (Advisor)
Ph.D. Student	Associate Professor
Phone #: (780) 451-7632 or (204) 949-5354	Phone #: (780) 492-7584 or 492-9415

Faculty of Agriculture, Forestry and Home Economics
University of Alberta
Edmonton, AB

What is the purpose of the study?

The information is being collected for use in a study on Healthy Start for Mom & Me. The purpose of the study is to describe Healthy Start for Mom & Me through the experiences of participants, program staff and community partners. The information collected will help Healthy Start for Mom & Me provide better services for pregnant women.

What will happen?

In order to understand how the program works, and to learn about participants' experiences, the researcher will collect information in many ways. Two group interviews will be held with participants at Freight House (200 Isabel Street) and Magnus Eliason Recreation Centre (430 Langside Street). A trained facilitator will lead the focus group interviews. The researcher will observe the group interviews to ensure that the important points are not missed. The group interviews will be scheduled on alternate weeks to the drop-in sessions. They will take place at the same time of day that the drop-ins are normally offered. Each group interview will be about 11/2 hours. Group interviews will be tape-recorded and typed notes will be prepared based on the taped interviews. Participants will be asked to review the typed notes to make sure that they are correct. Each focus group participant will be offered a $25.00 honorarium. The trained facilitator will also be offered an honorarium.

What are the benefits and risks of participation?

The benefits to the study include sharing ideas and experiences to better understand how Healthy Start for Mom & Me operates. The information will help staff to improve the program and make sure that it continues to meet the needs of participants. There are no known risks to participating in the study.

Is the information collected confidential?

All personal information will be removed from written and spoken study information. Only the researcher will be able to obtain personal information. Study information will be kept in a locked filing cabinet in the researcher's office. All information that can link people to the study will be destroyed after reports are written.

All study participants are free to withdraw from the study at any time without any result.

CONSENT FORM – TRAINED FACILITATOR OF FOCUS GROUPS

Part 1 (to be completed by the researcher)

Title of Project:
A Case Study Of Healthy Start For Mom & Me: A Prenatal Nutrition And Health Promotion Program Based On Education, Community Participation And Capacity Building.

Principal Investigator (Advisor)	Co-investigator (Student Researcher)
Kim Raine-Travers	Ellen Vogel
Associate Professor	Ph.D. Student
Phone #: (780) 492-7584 or 492-9415	Phone #: (780) 451-7632 or (204) 949-5354

Faculty of Agriculture, Forestry and Home Economics
University of Alberta
Edmonton, AB

Part 11 (to be completed by the research participant)

Do you understand that you have been asked to be in a research study?
Yes No

Have you read and received a copy of the attached Information Sheet?
Yes No

Do you understand the benefits and risks involved in taking part in this research study?
Yes No

Have you had an opportunity to ask questions and discuss this study?
Yes No

Do you understand that you are free to refuse to participate or withdraw from the study? at any time? You do not have to give a reason.
Yes No

Has the issue of confidentiality been explained to you?
Yes No

Do you understand how the information collected in the study will be used?
Yes No

Do you understand that the information shared by participants in the focus group interviews is confidential and not to be disclosed?
Yes No

I have been offered an honorarium for my participation.
Yes No

This study was explained to me by: ______________________________

I agree to take part in this study.

Signature of Research Participant	Date	Witness
JC Printed Name		Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator	Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM

APPENDIX F

INFORMATION LETTER AND CONSENT FORM–FOCUS GROUP INTERVIEWS

Information Sheet for Focus Group Participants

Title of the Project:

A Case Study Of Healthy Start For Mom & Me: A Prenatal Nutrition And Health Promotion Program Based On Education, Participation And Capacity Building.

Researchers:

Ellen Vogel
Ph.D. Student
Phone #: (780) 451-7632 or (204) 949-5354

Kim Raine-Travers
Associate Professor
Phone #: (780) 492-7584 or 492-9415

Faculty of Agriculture, Forestry and Home Economics
University of Alberta
Edmonton, AB

Purpose of the study?

The information is being collected for use in a study on Healthy Start for Mom & Me. The study will describe Healthy Start for Mom & Me through the experiences of participants, program staff and community partners. The information collected will help Healthy Start for Mom & Me provide better services to pregnant women.

What will happen?

In order to learn how the program works and to understand the experiences of participants, the researcher will collect information in many ways. Two group interviews will be held with participants. Each group interview will take about 11/2 hours. The interviews will take place at Freight House at 1415 Burrows Street and at Magnus Eliason Recreation Centre at 430 Langside Street. The group interviews will not be scheduled on the same weeks as the drop-in sessions. They will take place at the same time of day that the drop-ins are normally offered. Group interviews will be tape-recorded and typed notes will be prepared based on the interviews. Participants will be asked to review the typed notes to make sure they are correct. A trained facilitator will lead the group interviews. The researcher will observe the group interviews and will take notes to ensure that important points are not missed. Each focus group participant will each be offered a $25.00 honorarium. Transportation to the site and child-care will be provided at no cost if necessary. A snack (pizza and beverage) will be offered to participants at the end of the group interview.

Benefits and risks of the research?

The benefits to the research include sharing ideas and experiences to better understand how Healthy Start for Mom & Me operates. The information will help staff to improve the program and make sure that it continues to meet the needs of participants. There are no known risks to participating in the study.

Is the information collected confidential?

All personal information will be removed from written and spoken study information. Only the researcher will be able to obtain personal information. Information collected will be kept in a locked filing cabinet in the researcher's office. All information that can link people to the study will be destroyed after reports are written.

All study participants are free to withdraw from the study at any time without any result.

Consent Form - Focus Group Interview Participants

Part I (to be completed by the researcher)

Title of Project: A Case Study of Healthy Start For Mom & Me: A Prenatal Nutrition Program Based On Education, Community Participation and Capacity Building.

Principal Investigator (Advisor)	Co-investigator (Student Researcher)
Kim Raine-Travers	Ellen Vogel
Associate Professor	Ph.D. Student
Phone #: (780) 492-7584	Phone #: (780) 451-7632 or (204) 949-5354

Faculty of Agriculture, Forestry and Home Economics
University of Alberta, Edmonton, AB

Part II (to be completed by the research participant)

Do you understand that you have been asked to be in a research study? ☐ yes ☐ no

Have you read and received a copy of the attached Information Sheet? ☐ yes ☐ no

Do you understand the benefits and risks involved in taking part in this research study? ☐ yes ☐ no

Have you had an opportunity to ask questions and discuss this study? ☐ yes ☐ no

Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason. ☐ yes ☐ no

Has the issue of confidentiality been explained to you? Do you understand who will have access to audio-taped transcripts? ☐ yes ☐ no

I have been offered an honorarium of $25.00 for my participation. ☐ yes ☐ no

Do you understand how the information collected in the study will be used? ☐ yes ☐ no

This study was explained to me by: ________________________________

I agree to take part in this study.

______________________	__________	______________________
Signature of Research Participant	Date	Witness
______________________		______________________
Printed Name		Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

______________________	__________
Signature of Investigator	Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM

APPENDIX G

CONSENT FORM--TRANSCRIPT RELEASE

Transcript Release Form

Dear ______________________,

Thank you for your participation in my study. Please review the attached typed interview notes for any errors, inappropriate information, or missing information that you wish to correct. I look forward to receiving your signed release form. Please return the notes to me with your corrections. A self-addressed stamped envelope is provided for your response. If you have any concerns with the attached information, I can be contacted by E-mail, telephone or fax. If you are calling long distance, please reverse the charges.

Your signature below indicates your voluntary participation in this study and confirms the accuracy of the typed notes. Thank you again for your cooperation.

Sincerely,

Ellen Vogel
Ph.D. Student
Faculty of Agriculture, Forestry and Home Economics
University of Alberta

Phone #: (780) 451-7632
Fax #: (780) 447-2007
E-mail: wdm@gpu.srv.ualberta.ca

____________________________________ _______________
Participant's Signature Date

____
Participant's Name (printed)

APPENDIX H

SEMISTRUCTURED INTERVIEW GUIDE--FOCUS GROUP

Focus Groups with Healthy Start for Mom & Me Participants

Length of Interview: Approx. 11/2 hours

Research Question #1: What are the experiences of participants, program staff and community partners, and key representatives of the broader community in the prenatal health promotion program?

Tell me about your experiences in Healthy Start for Mom & Me.

If I had been in the program with you, what would I have seen you doing (or what experiences would I have observed you having) at a drop-in session?

When you walk through the door of the centre, on your way to a drop-in session, how do you feel?

When you walk through the doors of the centre, on your way home from a drop-in session, how do you feel?

Research Question #2: How have the lives of participants changed over the period of their involvement in the program?

What difference has the program made in your life?

Research Question #3: What difference has the program made to the inner-city communities that it serves?

What difference has the program made in your community?

Research question #4: What are the strengths and weaknesses of the program?

What do you like about the program?

What do you think should be improved?

What do you think should stay the same?

What are the factors that come together to make the program what it is?

How would you describe the program to a friend?

Research Question #5: How are participants brought into the program and how do they move through the program once they become participants?

How did you hear about the program?

Why did you come to the program?

What keeps you coming back to the program?

Research question #6: What is the nature of the interaction between participants, program staff and staff contributed from partner agencies and organizations?

How do you feel about your contact with program staff at a drop-in session?

What can you tell me about your experience with program staff between drop-in sessions?

Is there anything else about Healthy Start for Mom & me that you'd like to share with me?

APPENDIX I

INFORMATION LETTER AND CONSENT FORM–INDIVIDUAL INTERVIEWS WITH PROGRAM STAFF AND COMMUNITY PARTNERS

Consent Form - Individual Interviews with Program Staff and Community Partners

Part I (to be completed by the researcher)

Title of Project: A Case Study Of Healthy Start For Mom & Me: A Prenatal Nutrition Program Based On Education, Community Participation And Capacity Building.

Principal Investigator (Advisor)	Co-investigator (Student Researcher)
Kim Raine-Travers	Ellen Vogel
Associate Professor	Ph.D. Student
Phone #: (780) 492-7584	Phone #: (780) 451-7632 or (204) 949-5354

Faculty of Agriculture, Forestry and Home Economics
University of Alberta, Edmonton, AB

Part II (to be completed by the research participant)

Do you understand that you have been asked to be in a research study? ☐ yes ☐ no

Have you read and received a copy of the attached Information Sheet? ☐ yes ☐ no

Do you understand the benefits and risks involved in taking part in this research study? ☐ yes ☐ no

Have you had an opportunity to ask questions and discuss this study? ☐ yes ☐ no

Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason. ☐ yes ☐ no

Has the issue of confidentiality been explained to you? Do you understand who will have access to audio-taped transcripts? ☐ yes ☐ no

Do you understand how the information collected in the study will be used? ☐ yes ☐ no

This study was explained to me by: ____________________________________

I agree to take part in this study.

_________________________ _______________

Signature of Research Participant Date Witness

_________________________ _______________

Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_________________________ ______________

Signature of Investigator Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM

APPENDIX J

SEMISTRUCTURED INTERVIEW GUIDE--PROGRAM STAFF AND COMMUNITY PARTNERS

Individual Interviews with Program Staff and Community Partners

Length of Interview: 1-1/2 hour

Research Question #1: What are the experiences of participants, program staff and community partners, and key representatives of the broader community in Healthy Start for Mom & Me?

Tell me about your experience with Healthy Start for Mom & Me?

How would you describe your involvement in the Healthy Start for Mom & Me program?

What is the best part of your work?

What is the most challenging part of your work?

What would help you do your job better?

Research Question #2: How have the lives of participants changed over the period of their involvement in the program?

From your perspective, how have the lives of participants changed over the period of their involvement in the program?

Research Question #3: What difference has the program made in the inner city community that it serves?

What impact has the program had on the broader community?

Research Question #4: What are the strengths and weaknesses of the program?

What do you like about the program?

What do you think should be improved?

What do you think should stay the same?

What are the factors that come together to make the program what it is?

How would you describe the program to a friend?

Research Question #5: How are participants brought into the program and how do they move through the program once they become participants?

How are participants brought into the program?

What keeps participants coming to the program?

Research Question #6: What is the nature of the interaction between participants, program staff and staff donated from partner agencies and organizations?

How would you describe your relationship with other members of the Healthy Start for Mom & Me team?

How has the nature of your relationship with team members changed over time?

Research Question # 7: What are the factors that influence community partners' decisions to participate in the program?

What are the factors that influence community partners' decisions to contribute staff and resources to the program?

Research Question #8: How has active involvement in the program changed stakeholders' understanding of prenatal health promotion?

How has your involvement in the program changed your understanding of prenatal health promotion?

What difference has the program made in your life over the period of your involvement?

Research Question #9: What issues and tensions emerge from the program's peer outreach worker practice with marginalized women and their families?

What issues or tensions have arisen in the process of implementing the program? How were these issues or tensions resolved?

Research Question #10: How does interdisciplinarity challenge the norms and values of the practitioners' profession?

What issues or tensions have emerged as a result of working in interdisciplinary teams? How were these issues or tensions resolved?

Is there anything else about your involvement in Healthy Start for Mom & Me that you'd like to share with me?

APPENDIX K

INFORMATION LETTER AND CONSENT FORM–ELITE INTERVIEWS

Information Sheet for Key Informants

Title of the Project:

A Case Study of Healthy Start For Mom & Me: A Prenatal Nutrition Program Based On Education, Participation and Capacity Building.

Researchers:

Ellen Vogel	Raine-Travers (Advisor)
Ph.D. Student	Associate Professor
Phone #: (780) 451-7632 or (204) 949-5354	Phone #: (780) 492-7584

Faculty of Agriculture, Forestry and Home Economics
University of Alberta, Edmonton, AB

Purpose of the study?

The information is being collected for use in a study on Healthy Start for Mom & Me. The study will describe Healthy Start for Mom & Me through the experiences of participants, program staff and community partners. The information collected will help Healthy Start for Mom & Me provide better services for pregnant women.

What will happen?

In order to understand how the program works the researcher will collect information in many ways. Key informants, identified through "snowball sampling," will be interviewed by the researcher. The researcher is interested in learning about factors influencing community participation in Healthy Start for Mom & Me. Each interview will last about 11/2 hours and will be tape-recorded. Typed notes will be prepared based on the taped interviews. Participants will be asked to review the typed notes to make sure that they are correct.

What are the benefits and risks of participation?

The benefits to the research include sharing ideas and experiences to better understand how Healthy Start for Mom & Me operates. The information will help staff to improve the program and make sure that it continues to meet the needs of participants. There are no known risks to participating in the study.

Is the information collected confidential?

All personal information will be removed from written and spoken study information. Only the researcher will be able to obtain personal information. Information collected will be kept in a locked filing cabinet in the researcher's office. All information that can link people to the study will be destroyed after reports are written.

All study participants are free to withdraw from the study at any time without any result.

APPENDIX L

SEMISTRUCTURED INTERVIEW GUIDE–ELITE INTERVIEWS

Elite Interviews With Key Informants

Length of Interview: 1-1/2 hours

Research Question #1: What are the experiences of participants, program staff and community partners, and key representatives of the broader community in Healthy Start for Mom & Me?

Tells me about your experience with Healthy Start for Mom & Me.

What is the nature of your involvement with Healthy Start for Mom & Me?

How did you become involved with the program?

Research Question #2: How have the lives of participants changed over the period of their involvement in the study?

From your perspective, what difference has the program made in the lives of participants?

Research Question #3: What difference has the program made in the inner city community that it serves?

From your perspective, what impact has the program had on the broader community?

Who, in your opinion, determines the goals of the program?

Who acts, on behalf of the program, to achieve the program goals?

Who do you think receives the benefits of the action?

Based on your experience with the program, who evaluates the actions?

Research Question #4: What are the strengths and weaknesses of the program?

What do you like about the program?

What do you think should be improved?

What should stay the same?

How would you describe the program to a family member?

What are the factors that come together to make the program what it is?

Research Question #7: What are the factors that influence community partners' decisions to participate in the program?

What are the factors that influence community partners' decisions to contribute staff and resources to the program?

Research Question #8: How has active involvement in the program changed stakeholders' understanding of prenatal health promotion?

How has the program changed your understanding of prenatal health promotion?

Is there anything else about your involvement in Healthy Start for Mom & Me that you'd like to share with me?